Cedar Rapids Counseling
&Psychotherapy Group, LLP

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319- 362-0632 (ext. 3-Alexandria)
319-362-5206 (fax)

Authorization to Release Protected Health Information *(page 1)*

Client name: _____ Client date of birth**:** _____

I, the undersigned, hereby authorize Alexandria Carey, LISW at Cedar Rapids Counseling & Psychotherapy Group, LLP to release and exchange protected health information (via U.S. Mail, phone, or fax) from my clinical record with:

Name: _____
Address: _____
City/State/Zip Code: _____ Phone: _____

Relationship to client: _____

I understand the checked information below may be included. I understand Alexandria Carey cannot re-release any confidential information she received from another entity during or after the course of my treatment.

____ Medical
____ Psychiatric
____ Psychological
____ Financial/insurance information
____ Substance and alcohol abuse information
____ HIV/AIDS-related information
____ Other: _____
_____

This information is to be used for the following purpose(s):

____ Coordination of care with another health care provider
____ Coordination with a collateral source for the purpose of: _____
____ Other: _____

I understand that:

1. As long as I remain in treatment with Alexandria Carey, this authorization will expire **one year** from the date of my signature on page 2 unless indicated here: _____
2. This release automatically expires when I formally terminate my treatment with Alexandria Carey by verbal or written notice.
3. This release automatically expires if I have no contact with Alexandria Carey for a period of time longer than one month.
4. I have the right to revoke this authorization by providing a written notice to Alexandria Carey. If I am unable to do so on my own, I have been informed that Alexandria Carey will assist me in preparing the revocation.
5. I understand that the revocation is effective the date it is received and that any information released prior to the revocation will not constitute a breach of confidentiality. The revocation will not be effective if the authorization was obtained as a condition for receiving health insurance coverage for services, and the insurer has a legal right to contest a claim.
6. I have a right to inspect the health information disclosed and to receive a copy of this authorization upon my request.

Client name: _____ Client date of birth**:** _____

By signing below, I confirm that I have reviewed page one of the "Authorization to Release Protected Health Information" form.

_____ Self Parent Legal Guardian _____
Signature of client, parent, or legal guardian *(relationship to client)* Date

_____ Psychotherapist _____
Alexandria Carey, LISW *(relationship to client)* Date

********** Record of Authorization Extensions **********

By signing below, I confirm I was given the opportunity to review this "Authorization to Release Protected Health Information" form and agree to its extension for an additional:

1. First Extension *(starting at signature date below)*

____ 6 months ____ 1 year _____ Other: _____

_____ Self Parent Legal Guardian _____
Signature of client, parent, or legal guardian *(relationship to client: circle one of the above)* Date

_____ Psychotherapist _____
Alexandria Carey, LISW *(relationship to client)* Date

2. Second Extension: *(starting at signature date below)*

____ 6 months ____ 1 year _____ other: _____

_____ Self Parent Legal Guardian _____
Signature of client, parent, or legal guardian *(relationship to client: circle one of the above)* Date

_____ Psychotherapist _____
Alexandria Carey, LISW *(relationship to client)* Date

WARNING: The confidentiality of this information is protected by Federal Laws including the Health Insurance Portability and Accountability Act of 1996 and the Code of Federal Regulations (42 CFR Part 2, Public Law 93-282, Section 2.31(a) and 2.33) as well as Iowa law (Iowa Code Chapter 228). Iowa law requires that disclosures can only be made pursuant to the written authorization of the patient or patient's legal representative. The unauthorized disclosure or re-disclosure of mental health information is unlawful. Civil and/or criminal penalties may apply to the unauthorized disclosure of mental health information.