Cedar Rapids Counseling &Psychotherapy Group, LLP

4403 1st Ave SE, Ste 309
Cedar Rapids, IA 52402-3221
(319) 362-0632

Authorization to Release Information

Client name: _____ Client date of birth**:** _____
I, the undersigned, hereby authorize Penny Freeman, LISW at Cedar Rapids Counseling & Psychotherapy Group, LLP to release and exchange protected health information (via mail, phone, or fax) from my clinical record to:

Name: _____
Street address: _____
City/State/Zip Code: _____ Phone: _____

The following information may be included:
____ Medical: Evaluation or treatment reports
____ Psychiatric: Evaluation reports, clinical notes, discharge summary
____ Psychological: Evaluation reports, test results, PHI progress notes
____ Substance and alcohol abuse information _____HIV/AIDS-related information
____ Educational information _____Financial/insurance related information
_____ Permission to fax information *(if records are inadvertently received by an unauthorized recipient, through no fault of the sender, I waive claim against the sender)*
____ Other: _____

This information is to be used for the following purpose:

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

I understand that:

1. This authorization will remain in effect for one year unless otherwise specified here: (_____)
2. I have the right to revoke this authorization by sending a written notice to Penny Freeman, LISW at the above address. 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.
3. I have a right to inspect the health information disclosed.
4. I have a right to receive a copy of this authorization upon my request.

_____ Myself Parent Legal Guardian _____
Signature of client, parent, or legal guardian *(relationship to client: circle one of the above)* 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 redisclosure of mental health in formation is unlawful. Civil and/or criminal penalties may apply to the unauthorized disclosure of mental health information.