Serving Southwest Iowa
Therapy, Groups, Assessments
PCIT, EMDR, Psychiatric Services
Team Meetings, Aftercare Program
www.therapyplaceinc.com

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Mailing Address: P.O. Box #1
Panama Iowa, 51562
Offices In: Atlantic, Council Bluffs, and Waterloo

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, authorize the Release the following information:

_____ Attendance Only
_____ Diagnosis
_____ Diagnostic assessment
_____ Evaluation/Testing results
_____ Mental health treatment
_____ Health/Medical Information including HIV
_____ Case Consultation

____ Substance Use Disorder Diagnosis and Treatment
____ Substance Use Disorder Diagnosis and Treatment
____ Reports including Diagnosis, Attendance, Participation, Recommendations, Participation, Progress and Prognosis.
____ Termination/Discharge Summary
____ Other _____

Information to be released (**please circle**) _ TO: _ FROM: _ BOTH TO & FROM:

Name:		Phone:	
Company:		Fax:	

Regarding:

CLIENT/FAMILY NAME: _____
ADDRESS: _____
PHONE: _____

- The purpose for this disclosure is to facilitate effective treatment service coordination.
- A photocopy or exact reproduction of this form for release of information shall have the same effect as the original.
- This authorization will automatically expire one year from the date of signature unless a shorter period is specified (specific number of days/months): _____
- I understand that I may revoke this authorization at any time, except to the extent that information has already been released as authorized by giving written notice to Therapy Place, Inc., or their representative.
- I understand I have the right to review the disclosed information by contacting the office of Therapy Place, Inc. Once this authorization has expired or has been revoked, it can be renewed only by proper execution of another authorization.
- I acknowledge that information to be released may include material that is protected by state and/or federal law, including applicable mental health, alcohol/drug abuse, HIV/AIDS information, or all of these. My signature authorizes release of only the information specified above.
- I understand that information authorized by this consent cannot be released to anyone other than those listed above unless I give written permission. *Signature(s) indicates client/parent/guardian given a copy of the confidentiality/privacy policy for Therapy Place, Inc.

_____
(Client signature)

_____
(Signature of parent/guardian)
(If client under age 18)

_____
(Date)

_____
(Relationship to client)

_____
Witness
(Signature of Witness)