Serving Southwest Iowa
Therapy- Couples, Ind., Family, Groups, PCIT, EMDR, Parenting Assessments
Med. Management and Psychiatric Services
www.therapyplaceinc.com

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

AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT/FAMILY NAME:
ADDRESS: ____
PHONE: ____

I, the undersigned, authorize Therapy Place, Inc. to:
RELEASE TO, SECURE FROM, or EXCHANGE WITH:

(agency or organization)

information from the records of: __________________________ the following information:

__________ Diagnostic assessment
__________ Evaluation/Testing results
__________ Mental health treatment
__________ Termination/Treatment summary
__________ Substance Abuse Treatment
X – Other (specify) Case Consultation

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the disclosed information by contacting the office of Therapy Place, Inc. Once this authorization has expired or has been revoked, it can be renewed only by proper execution of another authorization.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)

__________________________ __________________________
(Signature of Therapist/Contractor) (Signature of parent/guardian) (If client under age 18)

____
(Relationship to client)

CC: Provider File for Client
Business File for Permission to be seen for billing purposes
DMS – reviewed 11/06/23