2130 Grand Avenue, Suite B
Des Moines, IA 50312-5365
(515) 270-0280
(515) 270-1647 (fax)
www.innovativelearningpros.com

DIGITAL AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Not all PDF viewers can digitally sign documents. Please try Adobe or Nitro if yours does not work.

Regarding [client name] ____ Date of Birth ____________________

I authorize Innovative Learning Professionals LC to either verbally and/or in writing (paper or electronic interchange) ☐release and/or ☐obtain the following protected health information:

- ☐ As much information as judged necessary
- ☐ Mental health information
- ☐ Substance abuse information
- ☐ HIV Status
- ☐ Progress Notes
- ☐ Academic/Educational Information
- ☐ Treatment Plan
- ☐ Admission/Discharge Summary(ies)
- ☐ Psychosocial History
- ☐ Psychotherapy/Process Notes
- ☐ Psychological testing [If release includes raw data, it is to be released directly to________________________].
- ☐ Other [specify] ____

To/from [agency or person]: ____

For the purpose of: ____ .

This release shall be renewed on an annual basis, unless further restricted as indicated:

- ☐ Authorization ends upon release of information noted above.
- ☐ Valid through three months beyond last face-to-face contact.
- ☐ Other [specify] ____.

I understand I have the right to inspect any written information released through this authorization and such an inspection, if requested, will occur in a meeting.

I understand I may revoke this authorization by providing written notice of revocation. I also understand any information released prior to the revocation may be used for the purpose listed above.

I understand I do not have to sign this authorization. Treatment, payment, enrollment, or eligibility for benefits cannot be conditioned upon the signing of this authorization.

I understand if the person or organization that receives my information (described above) is not a health care provider or health insurer the information may no longer be protected by federal or state privacy regulations (e.g., HIPAA and other privacy regulations).

I understand and agree that a copy of this authorization (including electronic copy, fax, or photocopy) shall have the same force as the original.

NOTICE TO PERSON/AGENCY RECEIVING MENTAL HEALTH INFORMATION: The mental health information disclosed herein has been disclosed, and may only be redisclosed, pursuant to the written authorization of the client or the client's legal representation or as otherwise provided in Chapter 228, Code of Iowa. Any unauthorized redisclosure of mental health information is unlawful and is subject to civil and criminal penalties.

Signature ____ Date__________ Relationship ______________

Signature ____ Date__________ Relationship ______________

Please choose what you would like to do to with the above document: