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## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

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:

- |  |   |
|--|---|
| <input type="checkbox"/> As much information as judged necessary   | <input type="checkbox"/> Academic/Educational Information |
| <input type="checkbox"/> Mental health information   | <input type="checkbox"/> Treatment Plan                   |
| <input type="checkbox"/> Substance abuse information   | <input type="checkbox"/> Admission/Discharge Summary(ies) |
| <input type="checkbox"/> HIV Status  | <input type="checkbox"/> Psychosocial History             |
| <input type="checkbox"/> Progress Notes  | <input type="checkbox"/> Psychotherapy/Process Notes      |
| <input type="checkbox"/> Psychological testing [If release includes raw data, it is to be released directly to _____]. |   |
| <input type="checkbox"/> 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 \_\_\_\_\_