

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

**Keys to Living Counseling Center
5250 North Park PI NE, Suite 209
Cedar Rapids, IA 52402
319/377-2161**

Patient name: _____ Birthdate: _____

Social Security No: _____

I understand that the specific information to be disclosed includes the following and that I have a right to inspect the disclosed information at any time. I understand that I can revoke my consent in writing at any time, and if I do not revoke this consent, it will expire automatically one year after the date signed below.

I hereby authorize _____
(Name of individual or institution)

(Address)

to disclose, exchange with, and deliver information to _____
(Name of individual or institution)

(Address)

for the purposes of evaluation, treatment planning, security, claims evaluation and payment. Further disclosure of this information to another party is unlawful and can result in criminal and civil penalties unless authorized by the client.

Initial YES NO (Please place check mark under yes or no and initial beside each option)

- | | | | |
|-------|-------|-------|--|
| _____ | _____ | _____ | MENTAL HEALTH INFORMATION |
| _____ | _____ | _____ | SUBSTANCE ABUSE(drug or alcohol)INFORMATION |
| _____ | _____ | _____ | AIDS-RELATED INFORMATION |
| _____ | _____ | _____ | DISCLOSURE necessary for claims processing/third party payor |

I acknowledge that information released may include material that is protected by federal or state laws applicable to the diagnosis and treatment of substance abuse, mental illness, and AIDS-related conditions. I understand that my Records may be protected under the Federal Confidentiality Regulations (42 CFR Part 2) and, if so, cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Keys to Living Counseling Center. Revocation is effective upon receipt of such request.

Signature of patient/client

Date

Signature of parent/legal guardian

Signature of witness