Don Damsteegt, Ph.D.- Licensed Psychologist-Owner

AUTHORIZATION TO RELEASE INFORMATION

Patient Name:_____ Patient Date of Birth: _____

I hereby authorize _____to release to and/or obtain from:

_____ _____
(Name of Recipient) (Address, City, State, Zip)

_____ _____, protected information from my clinical records.
(Telephone Number) (Fax Number)

The following information may be included:

_____Medical: Evaluation or treatment reports
_____Psychiatric: Evaluation reports, clinical notes, discharge summary
_____Psychological: Evaluation reports, test results, psychotherapy progress notes
_____Substance and alcohol abuse information
_____HIV/AIDS-related information
_____Other information as indicated_____

The information is to be used for the following purpose (s).____

_____

This authorization will remain in effect until _____.
(Date)

I understand that I may revoke this authorization by sending a written notice to Family Psychology Associates, P.C. at 1221 Center Point Road N.E., Cedar Rapids, IA, 52402. The revocation becomes effective when it is received. I understand that any information released prior to a revocation and which was released because of this authorization will not constitute a breach of confidentiality. Also, the revocation will not be effective if the authorization was obtained as a condition for receiving insurance coverage for services, and the insurer has a legal right to contest a claim.

I further understand that I have a right to inspect the health information disclosed.

I understand that Iowa law prohibits re-disclosure of the information by the recipient of the disclosed information.

I understand that my health care and payment for my health care will not be affected if I do not sign this form.

I know that I am entitled to receive a copy of this authorization: **accept** or **decline** (please circle one)._____

_____ _____
(Signature of patient or legal guardian) (Type of relationship to patient)

_____
(Date)

WARNING: The confidentiality of this information is protected by Federal Laws including the Health Insurance Portability and Accountability Act of 1996 and the Code of Federal Regulations (42 CFR Part 2, Public Law 93-282, Sections 2.31 (a) and 2.33) as well as Iowa law (Iowa Code Chapter 228). Iowa law requires that disclosures can only be made pursuant to the written authorization of the patient or patient=s legal representative. The unauthorized disclosure or re-disclosure of mental health information is unlawful. Civil and/or criminal penalties may apply to the unauthorized disclosure of mental health information.

1221 Center Point Road NE, Cedar Rapids, IA 52402

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