West Des Moines
CENTER FOR
PSYCHOTHERAPY

1045 76th Street, Suite 3030
West Des Moines, IA 50266
515.777.3388 (P)
515.777.3387 (F)

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

RELEASE FROM:

Today's Date: _____

Client: _____

DOB: _____

RELEASE TO (PERSON/INSTITUTION):

Name: _____

Address: _____

City, State, Zip: _____

E-Mail: _____

Phone: _____ Fax: _____

I authorize my psychologist, _____ to release to the above named person or institution:

- ☐ Psychological Evaluation
- ☐ Assessment & Diagnosis
- ☐ Progress Notes
- ☐ Other_____
- ☐ Treatment Plan
- ☐ Closing Summary
- ☐ Statement of Charges

I authorize the above named person or institution to release to my psychologist, _____ .

- ☐ Psychological Evaluation
- ☐ Assessment & Diagnosis
- ☐ Progress Notes
- ☐ Other_____
- ☐ Treatment Plan
- ☐ Closing Summary
- ☐ Statement of Charges

The information is being used only for: _____

I understand that I may revoke this release at any time, otherwise, this release will automatically expire one year from the date of signature. I also understand that I may revoke this authorization before it expires by providing a written revocation. I further understand that I have the right to inspect disclosed information under appropriate conditions established by my psychologist. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that if the persons or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. However, there may be other federal or state lws that require the information to remain confidential.

I understand that my psychologist cannot guarantee the confidentiality of documents transmitted by fax or email. I consent to information to be transmitted by: **Fax:** ☐ Yes ☐ No **E-mail:** ☐ Yes ☐ No

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW.
No information released under this authorization may be redisclosed without the written permission of the client. I specifically authorize the release of information relating to:

Substance Abuse (alcohol/drug abuse)..... ☐ Yes ☐ No _____ (Initial)
Mental Health (includes psychological testing)..... ☐ Yes ☐ No _____ (Initial)
HIV-Related Information (AIDS related testing) ..... ☐ Yes ☐ No _____ (Initial)

_____ _____
Client Signature or Client's Authorized Representative Date

_____ _____
Licensed Psychologist Date