Turner Therapy and Counseling, LLC

Authorization for Release of Information

Client Name:_____ **Date of birth:**_____

Turner Therapy and Counseling LLC **4300 S Lakeport Street Suite 101** **Sioux CIty, IA 51106** **600 4th Street Suite 700** **Sioux CIty, IA 51104** **24 1St Street NW** **Le Mars, IA 51031**	**I, the undersigned, hereby authorize Turner Therapy and Counseling to obtain and Release information from my record to:**

Information to be released: (check all that apply)

__Biopsychosocial Assessment __Discharge or Closing Summary __Prognosis

__Progress Notes __Consultation Reports __Other

__Entire health records (including but not limited to: information regarding medical/health treatment, demographics, and referral documentation)

This authorization will automatically expire (1) year from the date of signature or on a specified date of _____.

- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action had already been taken in reliance upon it.
- I understand that any information released prior to the revocation may be used for the purpose listed above, and does not constitute a breach of my rights and confidentiality.
- I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and once the information is disclosed, it may no longer be protected by federal privacy regulations.
- I understand that I may review the disclosed information by contacting the recipient named, or Turner Therapy.

I understand that I can refuse to sign this authorization, but failure to provide access to information necessary for the funding and implementation of services may be a basis for denial of services.
Specific Authorization for release of information is protected by state and federal law.
I understand that the information to be released may be included in the following categories:

__Mental Health

__Substance Abuse(alcohol/drug abuse)

__HIV-related information

Client signature:_____ Printed Name:_____

Parent and or guardian signature:_____

Relationship to client_____ Date_____

Confidential or mental health information is protected by federal and state law, Chapter 228 of the Iowa Code and Federal regulations governing Confidentiality of Alcohol and Drug Abuse Client records, 42 CFR Prt.2, and cannot be disclosed without my written consent. UNAUTHORIZED DISCLOSURE MAY RESULT IN CIVIL DAMAGES AND CRIMINAL PENALTIES.