Green Counseling Services

Promoting Strength, Health, and Resilience

Authorization to Obtain and/or Release Medical Information

Client's Name: ____ DOB: ______________

I authorize Green Counseling Services, PLLC to disclose and/or receive written and/or verbal information with:

Name of Individual/Organization: ____

Address: ____ Phone: ____________

the folowing information:

☐ Social History ☐ Evaluations ☐ Diagnosis ☐ Lab Work

☐ Test Results ☐ Treatment Plan ☐ Medication History

☐ Discharge ☐ Other: ____

for the purpose(s) of:

☐ Evaluation ☐ Treatment ☐ Case coordination ☐ Placement

☐ Reimbursement ☐ Other: ____________________________________

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I authorize the release of the information listed below, which requires specific consent under federal law: (check all that apply, *depending on what is checked we may be unable to fulfill this authorization.)*

☐ Mental Health ☐ Substance Abuse* ☐ HIV/AIDS Information

**Only the client, regardless of age, can authorize release of substance abuse information.*

This authorization is effective for 1 year from the signed date unless authorization is revoked. 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 Green Counseling Services, PLLC. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by Green Counseling. I understand that my health care and payment for my healthcare will not be affected if I do not sign this form. I understand this authorization is voluntary. I understand that if the recipient of this information is not a health plan or provider, the released information may no longer be protected by federal privacy regulations and may be subject to re-disclosure. I understand that I am entitled to receive a copy of this completed authorization form. This information is protected by Chapter 228 and/or 141 of the Iowa Code or Federal Regulation 42 CFR Part 2 which prohibits further redisclosure without the written consent of the patient and Green Counseling Services, PLLC or as otherwise permitted by such law and/or regulation. A general authorization for the release of information is not sufficient for these purposes. Unauthorized disclosure is unlawful and civil damages and/or criminal penalties may apply. This authorization is intended to comply with HIPAA and Iowa law.

____ ______________________________

Signature of Patient or Authorized Representative *Date of Signature*

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Print Name/Relationship to Patient