

233 S. Second St, P.O. Box 130 Ph: (319) 643-2532

West Branch, Iowa 52358 Fax: (319) 643-5708

***FAMILIES, Inc. Building Family Strengths Since 1974***

**Consent to Release and Obtain Information**

**Two Way Reciprocal Release**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned, authorize Families, Inc. to release to, secure from, or exchange with:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be released/obtained:

Evaluation/Assessment, Social History, Diagnosis, Treatment of Service Plan, Treatment Progress, Discharge Summary, Behavior Intervention, Medications, and Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SPECIFIC AUTHORIZATION FOR RELEASE**I AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION WHICH REQUIRES SPECIFIC CONSENT UNDER FEDERAL OR STATE LAW: **Type of Information Authorizing Initials** Mental health evaluation/treatment \_\_\_\_\_\_\_\_\_\_\_ AIDS/HIV-related \_\_\_\_\_\_\_\_\_\_\_Substance abuse \_\_\_\_\_\_\_\_\_\_\_ |

I voluntarily allow the release or exchange of the above information. I understand this information will not be forwarded to anyone else by the recipient without my written consent. I understand this authorization does not extend to information not included in the specific request. I have been informed about my rights concerning current Federal confidentiality regulations (42 CFR, Part 2), and the Iowa Code Chapter 228. I understand I have the right to see this information at any time. I understand that I can revoke my consent at any time by providing written notification. This consent shall expire upon termination of services, or on the date specified below by the authorizing party. A photocopy of this signed Authorization shall have the same force and effect as this original.

Authorizing Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This agreement will expire one year from date of signature, unless previously revoked or otherwise indicated (specify date):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rev. 7/2020