KW COUNSELING SERVICES, LLC
2219 229th Place
Ames, IA 50014

Authorization To Release Private Healthcare Information

Client Name:______________________________ Phone: __________________DOB: ___________

Address: ____

When completed and signed by you, this form authorizes me to release protected information from your clinical record to the person you designate.

I authorize, **Kevin Willson, LMFT** to release and exchange:

____

This information should only be released to (name and address of person to whom the information is to be

released):____

I am requesting to release this information for the following purposes: ("at the request of the individual" is all that is required if you are a client and you do not desire to state a specific purpose):

__________AT THE REQUEST OF THE INDIVIDUAL____________________________

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure):

______ONE YEAR FROM DATE SIGNED____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to **2215 229th Place Ames IA 50014** and to the named recipient of the disclosed mental health information. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my psychotherapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand I have the right to inspect the disclosed mental health information at any time. I understand that Iowa law prohibits redisclosure by the recipient of information used or disclosed pursuant to this authorization.

____ ___________________

Signature of Client/Guardian/Representative Date

(If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the patient must be provided)

PLEASE SEE OTHER SIDE =>

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Authorization To Release Private Healthcare Information (Continued)

Client Name: ____

Prohibition on Re-disclosure:

This form does not authorize re-disclosure of information beyond the limits of consent. Where authorization has been re-disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 CFR, part 2) and state requirements (Iowa code Ch. 228) prohibits further disclosure without the specific written consent of the client or as otherwise permitted by such law and/or regulation. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may be attached for unauthorized disclosure of alcohol/drug abuse or mental health information.

Specific Authorization for release of Information Protected by State or Federal Law:
I specifically authorize the release of data and information relating to:

_____ 1. Substance Abuse PLEASE INITIAL

______2. Mental Health (including assessment inventories) PLEASE INITIAL

____
Signature of Client/Guardian/Representative

Date: ______________________________
In order for the above information to be sent, you must sign here