Turning Leaf Counseling

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Consent to Obtain and Release of Information

Name: _____Date of Birth: ____-____-_____

Address:_____

City\State:_____ Zip-Code:_____

Telephone:_____

Parent/Guardian:_____

Parent/Guardian Address: _____

I hereby authorize Turning Leaf Counseling and the following individuals or agencies to share written and oral information about my needs and services stipulated below.
Name/Agency

_____

_____

_____

The information released or shared may include:

Evaluation/Assessment, agency participation, plans, & progress reporting, Educational Assessment, Physical Status (including vision & hearing), communication skills, cognitive skills, Family & Social data, Health Status (including medical, dental, nutrition), X-rays, charts, photographs, Multi-axial Diagnosis. Other, specify_____

SPECIFIC AUTHORIZATION FOR RELEASE

I authorize the release of the following information, which requires specific consent under federal or state law:

_____ Yes _____ No Substance Abuse _____ Yes _____ No Mental Health

_____ Authorization to transmit information electronically (fax or e-mail)

State and/or federal law specifically requires that any disclosure of substance abuse (alcohol or drug), mental health, AIDS-related information must accompanied by the following written statement: this information has been disclosed to you for your records protected by federal confidentiality rules (42 cfr part2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 cfr part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient. See also chapter 228 of the Iowa Code and Section 141.23(3) of the Iowa Code and other applicable laws.

I understand this information shall be kept confidential and shall be used for the purpose of planning and delivering my service. I understand that I have the right to see this information at any time. This consent is valid for information already in existence and any information, which may be generated during future service involvement. I understand that I can revoke my consent at anytime by providing written notification. This consent shall expire upon termination of services, or on the date specified below by the authorizing party. I have read this form, or it has been read and explained to me, and I understand its content.

_____ /_____		_____	_____
Signature	Date	Relationship to client	Expiration Date
_____/_____		_____	_____
Signature	Date	Relationship to client	Expiration Date

_____ /_____
Therapist Date

A photocopy of this signed Authorization shall have the same force and effect as this original