Consent to the Release of Protected Health Information

New Leaf Counseling, PLLC Annika Ross, LISW

910 23rd Ave Ste 100, Coralville, IA 52241 Phone 319-351-9731, Fax 866-468-4419

Client's Legal Name: _____ DOB: _____

I authorize New Leaf Counseling, PLLC to:

_____ Release to _____ Obtain from

_____ (Name or Organization)

_____(Address)

_____(E-mail)

_____(Phone)_____ (Fax)

Information Covered by this release (check those that apply): ☐ Attendance ☐ Diagnosis ☐ Initial Assessment Information ☐ Treatment Summary ☐ Progress/Session Notes

Reason for release below (check those that apply): ☐ Moving out of area ☐ Rehab/disability ☐ Insurance ☐ Care/Treatment Coordination ☐ Transferring care ☐ Billing ☐ Other: _____

This consent is voluntary. If I cancel this consent at a later date, I must send written notification to New Leaf Counseling, PLLC at the above address. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information with proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask question by contacting New Leaf Counseling, PLLC at the above address.

I understand that the following information may be released electronically, and may include information in the following categories unless I specifically deny the release

(initial any area **NOT** to be released):

_____ Mental Health _____ Substance Abuse _____ HIV

Client or Legal Guardian Signature: _____**Date:** _____

Printed Name:_____

Relationship to client:_____

******Release expires one year from the date it is signed above.***