Thriving Families Counseling Services
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Des Moines, IA 50312
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www.thrivingfamiliesservices.com

Release of Information

Client: DOB:

I authorize: ____ of Thriving Families Counseling Services to exchange information with the following person(s) or agency:

____

Information to be Released:

- ___ Attendance
- ___ Treatment plan, progress, and discharge reports
- ___ Evaluation results & recommendations
- ___ Psychological & psychiatric testing and evaluation results
- ___ Information regarding social history
- ___ Information regarding medical history
- ___ Information regarding substance abuse (alcohol and drug abuse)
- ___ HIV/AIDS related testing and information
- ___ Others (specify)__________________________

Purpose of Release:

- ___ Legal investigation/ Court proceedings
- ___ Treatment collaboration
- ___ Determine eligibility for benefits
- ___ Emergency contact
- ___ Other (specify) ____________________

Formats information can be shared in:

- ___ verbal direct
- ___ email
- ___ written
- ___ telephone/text messaging
- ___ fax

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand what I have read and what was explained to me and agree to the terms and conditions stated above. Additionally, I understand either party may terminate this agreement at anytime by providing a letter or other written documentation regarding the request for termination. A photocopy or exact reproduction of this document shall have the same force and effect as this original. I understand that I have the right to refuse to sign this authorization.

Client Signature: ____ Date: ____________

Parent/Guardian/Rep: _____________________________________ Date: ____________

If you are the legal guardian or representative approximated by the court for the client, please attach a copy of this authorization to receive this protected health information.

TFSC Staff/ Witness: ____ Date: ____________

Date Release Expires: _________________