

**Front Line Therapy, LLC**

**3737 Woodland Ave Suite 620 West Des Moines, IA 50266**

**Phone: (515) 225-7124 Fax: (515) 446-9708**

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Patient's Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

I authorize the following parties

1) **Front Line Therapy, LLC and**

2) \_\_\_\_\_

NAME	ADDRESS	TELEPHONE
------	---------	-----------

.....to disclose the information initialed below from my medical records to one another:

**Please initial all that apply:**

_____ Discharge Summary	_____ History and Physical
_____ Social History	_____ Mental Health/Substance Abuse
_____ Laboratory, X-Ray, EKG	_____ Consultation
_____ Treatment Status	_____ Other (please specify) _____.

The information is being requested for the following purpose(s):

I understand that I may revoke this authorization by providing a written revocation to the parties named above at any time. I also understand that any information which has been released prior to the revocation may be used for the purposes listed above. This authorization is effective for:

**Please initial one of the following:** \_\_\_\_\_ twelve months \_\_\_\_\_ indefinitely until revoked

from the date on which it is signed. I understand that I may have a right to inspect disclosed information at any time and that such inspection will occur in a meeting with a member of the professional staff.

I acknowledge that the information to be released may include material that is protected by state and/or federal law applicable to either mental health or substance abuse or both. My signature authorizes release of all such information

\_\_\_\_\_  
Signature of Patient or Patient's Authorized Representative

\_\_\_\_\_  
Date

If authorized Representative. Relationship to Patient

**PROHIBITION ON REDISCLOSURE:** This form does not authorize redisclosure of Medical Information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for substance abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa code ch. 22) prohibits further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other Information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of substance abuse or mental health Information.