Gersh, Hartson, Payne, Hoffman and Associates, P.C.
373 Scott Court, Suite A
Phone: (319) 338-9960 Iowa City, IA 52245 Fax: (319) 338-9492

AUTHORIZATION TO DISCLOSE PROTECTED INFORMATION

_____ _____
Individual's Full Name Date of Birth Psychologist/Psychiatrist

I, the undersigned, hereby authorize the above named Clinician to: _____Disclose _____Obtain

Clinical notes pertaining to evaluation and treatment of the individual to/from:

_____
Name of Individual, Agency or School Fax Number

_____
Street Address City State Zip

The information will be used for: (specify reason for release of information) _____

I understand that the information may be released electronically, and may include information in the following categories unless I specifically deny the release (*initial*** any category ***not*** to be released).

Substance Abuse _____ Mental Health _____ HIV-related information _____

**This consent is voluntary. The completion of this form is not a required condition of evaluation or treatment.

I understand that this authorization is effective for twelve (12) months from the date on which it was signed. I understand that I may revoke this consent at any time by sending a written notice to the above named practitioner. I understand that any information released prior to any revocation and which was because of this authorization will not constitute a breach of confidentiality. I understand that I may review the disclosed information by contacting the records technician at the agency that will be releasing the information.

_____ _____
Signature of Client/Parent or Guardian if under 18 Date Witness Date

I understand and agree that should the records be inadvertently transmitted to an unauthorized recipient, through no fault of the sender. I hereby waive any claim against the sender and agree to hold the sender harmless from any and all responsibility for damages, if any, arising from the faulty transmission.

Please indicate if there is specific information that is to be released: _____