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AUTHORIZATION TO DISCLOSE PROTECTED INFORMATION

Individual's Full Name SS# Date of Birth Psychologist

I, the undersigned, hereby authorize the above named Psychologist to: _____ Disclose _____ Obtain
Clinical notes pertaining to evaluation and treatment of the individual to/from:

Name of Individual, Agency or School

Street Address City State Zip + 4

- _____ summary of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date
- _____ results of medical or psychological tests/evaluations
- _____ educational evaluations/IEP/504 Plans
- _____ medication prescription monitoring
- _____ Other information as indicated _____

The information will be used for: (specify reason for release of information, i.e. continuing medical care) _____

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 Date

Witness Date

Signature of Parent/Guardian Date

Witness Date

SPECIFIC AUTHORIZATION FOR INFORMATION PROTECTED BY STATE OR FEDERAL LAW:

I specifically authorize the release of information and data relating to: (initial appropriate lines)

- _____ Substance Abuse Information
- _____ Mental Health Information
- _____ HIV/AIDS related information

The confidentiality of this information is protected by Federal Law (42 CFR Part 2). Further disclosure is prohibited

Signature of Client Date

Witness Date

Signature of Parent/Guardian Date

Witness Date

Please initial appropriate lines below:

- _____ I authorize release of these records through facsimile transmission (FAX).
- _____ I authorize release of information through e-mail.

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.