Authorization For Release of Protected Health Information

I, _____, born ____/____/_____ authorize Mindset Counseling Group
(Name of client) (Client's birthday)

2. To send PHI to (initial) _____ and/or obtain PHI from (initial) _____ the following individual or organization:

3. Name of person or organization: _____

4. Located at:

Street Address: _____ City: State: Zip: _____Phone #:_____

5. I authorize the release of: (what info do you consent to release)

_____

_____

OR

As much information as either/both parties, in their full discretion, deem reasonably necessary for the purposes set forth by me for release. (initial) _____ **OR** I decline to release any information at this time (initial) _____

6. If applicable, I specifically authorize the release of material that is protected by state and/or federal law including (must initial at least one; if none, initial next to decline):

   a. Mental Health Information (initial) _____

   b. Substance Abuse Treatment (initial) _____

   c. HIV/AIDS Status (initial) _____

   d. I decline to release any of these special categories (initial) _____

7. The above information is being disclosed only for the purpose(s) of:

_____
Client Signature

_____
Parent/Guardian/Rep. Signature (if minor or under guardianship)

_____
State Relationship to Client (if minor or under guardianship)

_____
Date Signed

Prohibition on Redisclosure

This form does not authorize redisclosure of PHI beyond the limits of this consent. Where information has been disclosed from records protected by Federal law for alcohol/drug abuse records or by State law for mental health records, Federal requirements (42 C.F.R. Part 2, 45 C.F.R. HIPAA) and State requirements (Iowa Code Ch. 228) prohibit 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.

I have been informed what information will be given, its purpose, and who will receive the information. I understand that my provider generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. I understand that I have the right to inspect the information to be disclosed upon proper notification to and under appropriate conditions established by Central Iowa Psychological Services.

I understand that I may revoke this authorization at any time by providing written notice to my provider and to the named recipient of the disclosed mental health information. However, my revocation will not be effective to the extent that action has been taken in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. **After one year, this consent automatically expires**.