

**APOLLO COUNSELING AND RESOURCE CENTER, LLC
AUTHORIZATION FOR RELEASE OF INFORMATION**

NOTICE TO PERSON/AGENCY RECEIVING MENTAL HEALTH INFORMATION

The mental health information enclosed has been disclosed and may be disclosed pursuant to the written authorization of the client or the client's legal representative or as otherwise provided in Chapter 228, Code of Iowa. Any unauthorized disclosure of mental health information is unlawful and may result in civil damages and/or criminal penalties.

Client Name: _____ Date of Birth: _____

I authorize APOLLO CRC to release/ obtain information to/ from: _____

(Specify recipient agency and/or person)

Information to be released or obtained:

- | | |
|---|---|
| <input type="checkbox"/> Permanency Plan | <input type="checkbox"/> Psychological/psychiatric assessment/treatment |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Educational/Vocational information |
| <input type="checkbox"/> Medical Information | <input type="checkbox"/> Prescription Sheet Records |
| <input type="checkbox"/> Progress Reports | <input type="checkbox"/> Correspondence |
| <input type="checkbox"/> Legal Information | <input type="checkbox"/> Attendance |
| <input type="checkbox"/> Social History | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Treatment Plan (history) | |

This release will be used for the following purpose:

- | | |
|---|--|
| <input type="checkbox"/> Coordination of services | <input type="checkbox"/> Referral for new services |
| <input type="checkbox"/> Legal Representation | <input type="checkbox"/> Other: _____ |

Restriction Regarding this Release: This release expires one year from the date of signature except as specified. I understand that I have the right to inspect the information which will be released through this authorization and that such an inspection will occur in a meeting with the therapist and/or mental health professional(s). I understand that I may revoke this authorization by providing a written revocation to the recipient named above and to APOLLO CRC. I also understand that any information which has been released prior to the revocation may be used for the purposes listed above.

I understand that data to be released may include material that is protected by Federal or State law and that is applicable to either Drug/Alcohol Abuse or Mental Health Information or both. My signature authorizes release of all such information (as specified above).

Signature of Client / Guardian _____
Date

Signature of witness _____
Date

Specific authorization for release of information protected by state or federal law I specifically authorize the release of information relating to:	
<input type="checkbox"/> Substance abuse (alcohol/drug abuse)	
<input type="checkbox"/> HIV – related information (AIDS related testing)	
<input type="checkbox"/> Mental Health (including psychological testing)	
_____	_____
Signature of Consumer or Legal Guardian	Date

Prohibition on Re-disclosure: This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by Federal law for Alcohol/Drug abuse records or State law for Mental Health records, Federal requirements (42 CRR part 2) and State Requirements (Iowa code chapter 228) prohibits further disclosure without specific written consent of the client 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 alcohol/drug or mental health information.

“Helping families and individuals strengthen and enhance relationships through counseling, support, and advocacy.”

Mailing:

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