1811 Boyson Rd, Suite A
Hiawatha, IA 52233
319-693-5694
MWRCounseling@gmail.com

MURRAY, WILSON & ROSE
COUNSELING AND BEHAVIORAL SERVICES

Authorization to Release Information

Client Name: _____ Date of Birth: _____

I, the undersigned, hereby authorize Murray, Wilson & Rose Counseling and Behavioral Services, LLC to release/exchange protected health information to:

Name/organization: _____ Address: _____

Phone: _____

The following information may be included (please check):

- ❑ ALL health information about me
- ❑ Psychiatric/Psychological testing, evaluation, and recommendations
- ❑ Summaries and notes of participation in treatment
- ❑ Appointment/Insurance information only
- ❑ Social history
- ❑ Medical history
- ❑ Other: _____

Specific Authorization for Disclosure of Health Information Protected by State and Federal Law: *I acknowledge that information to be disclosed may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, and AIDS (please initial).*

_____ Substance and alcohol abuse information
_____ Mental health/Counseling information
_____ HIV-/AIDS-related information

This information is to be used for the following purpose(s):

❑ Coordination of care ❑ Medical ❑ Legal ❑ Other: _____

This authorization expires one year from the date of signature or until therapy is terminated, whichever is longer, unless previously revoked; or, if applicable, until the date of the final disposition of the conditional release or other court action in connection with which this consent is given (42 CFR 2.35 J(c)).

I understand that I may revoke this authorization by providing Murray, Wilson & Rose Counseling and Behavioral Services, LLC with written notice, with the revocation becoming effective when it is received and with the exception that the revocation will not have any effect on any action taken prior to the revocation. I further understand that I have a right to discuss and/or review information to be released and to correct any errors by notifying Murray, Wilson & Rose Counseling and Behavioral Services, LLC of these errors. I understand that Iowa law prohibits re-disclosure of the information by the recipient of this information. I know that I am entitled to receive a copy of this authorization. A photocopy or exact reproduction of this Authorization shall have the same effect as the original.

_____ _____ _____
Signature of Client or Legal Guardian Relationship Date

_____
Witness

____ Copy offered to client

Attention: The confidentiality of this information is protected by Federal Laws including the Health Insurance Portability and Accountability Act of 1996 and the Code of Federal Regulations (42 CFR Part 2, Public Law 93-282, Section 2.31(a) and 2.33) as well as Iowa Law (Iowa Code Chapter 228 and Section 141.23 (3) of the Iowa Code and other applicable laws. Iowa Law requires that disclosures can only be made pursuant to the written authorization of the patient or patient's legal representative. The unauthorized disclosure or re-disclosure of mental health information is unlawful.