Catholic Charities Center for Life Counseling
601 Grand Ave, Suite 200
Des Moines, Iowa 50309
(515) 237-5045

Authorization for Release of Information

Name of Client: _____

Address: _____

Date of Birth: ___/___/____ **I,** _____
(client's name)

hereby authorize _____ **from Catholic Charities Center for Life Counseling to release and/or exchange confidential info. to/with:**
(therapist's name)

_____
(name of person and/or position and organization to whom info. is to be released)

INFORMATION TO BE RELEASED

- ☐ Diagnosis for the purpose of Medicaid billing
- ☐ Evaluation and recommendation
- ☐ Social history
- ☐ Duration of involvement in program
- ☐ Legal history
- ☐ Diagnosis for the purpose of billing insurance company
- ☐ Summary of treatment
- ☐ Alcohol and other drug history
- ☐ Attendance at counseling sessions
- ☐ Other _____

Purpose for release_____

CLIENT RIGHTS

- You can end this authorization (permission to use or disclose information) any time by contacting: Catholic Charities Center for Life Counseling, 601 Grand Ave, Suite 200, Des Moines, Iowa 50309 515-237-5045.
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission.
- Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.
- You have a right to a copy of this signed authorization. Please keep a copy for your records.
- You do not have to agree to this request to use or disclose your information.

CLIENT AUTHORIZATION

I, the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire within and not to exceed one year from the date of signature, unless another date is specified. I have read and understand the above information and give my authorization:

_____ _____ _____ _____
(client's signature) (date) (witness/therapist signature) (date)

This authorization expires _____.
(date)

NOTICE TO RECIPIENT OF INFORMATION
This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Updated 5.8.2014