# Consent To Release of Information
## Creating Connections Counseling
**Please PRINT (except signatures) and provide complete information in each section.**

Patient Name_____ Birth Date_____
I understand that by signing this form I am allowing CCC to release information concerning the above-named patient to:

_____
Name of person and/or institution

_____
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

I understand and herby authorize regular exchange of information and/or copies of the following documents to be transferred between CCC and the above named person/institution subject to limitations as follow:

Transfer from CCC to above named person/institution yes____no_____
Transfer from above named person/institution to CCC yes____no_____

This information will include:

_____Treatment Plan & Reports
_____Reports to Third Party Payers
_____Psychological Testing
_____Discharge Summary
_____Medical & Psychiatric Reports
_____Educational Reports/Testing
_____Referral for Services
_____Intake Evaluation/Assessments

Other_____
As per my request, reason for release of information is:
☐ Medical care ☐Legal ☐Insurance ☐Other (specify) _____

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to the Clinic Director, 306 Scott Court, Iowa City, IA 52245. I understand that any release that was made prior to my cancellation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized re-disclosure and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Clinic Director at the above address.

I understand that the information to be released may include information in the following categories where I have specifically signed for release. Please **initial** to give permission for information in these specific categories to be released. You have the right to inspect the disclosed information related to these categories at any time. This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months)_____.

Substance Abuse_____Mental Health_____HIV-related information_____

This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR Part 2). The Federal rules prohibit you 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 42CFR 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.

_____
Signature of Patient or Legal Guardian Date

_____
Complete Mailing Address/Street/P.O. Box City/State/Zip Code

_____ _____
Relationship, if Not the Patient Witness Signature