1225 E. River Drive Suite 330 Davenport, Iowa 52803
Phone: 563-424-0136 www.insideoutqc.com

Authorization to Obtain, Disclose and Exchange PHI

Clients Name: _____ Date of birth: _____

Legal Guardian's Name (if applicable): _____

Relationship to Client: ☐ Self ☐ Parent/Guardian ☐ Representative ☐ Other: _____

AUTHORIZATION: The undersigned hereby authorizes Inside Out Counseling & Consulting to obtain from, disclose to, and exchange protected health information either orally or in writing.

Name/Agency: _____ Phone Number: _____

Address:

_____

Email: _____ Fax Number: _____

INFORMATION: I authorize the following PHI to be obtained, disclosed, and exchanged.

☐ Progress notes
☐ Notes of participation
☐ Treatment plan
☐ Treatment/Closing summary
☐ Mental health evaluations/recommendations
☐ Information related to developmental history
☐ Information related to medical history/evaluations
Information related to educational records

☐ Other:

_____

PURPOSE: The above information will be used to facilitate effective treatment service coordination and for the following purposes:

- ☐ Planning appropriate treatment/program
- ☐ Continuing appropriate treatment/program
- ☐ **Determining** eligibility for benefits/program
- ☐ Case review
- ☐ Updating files
- ☐ Other: _____

SPECIFIC AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION BY STATE & FEDERAL LAW

I acknowledge that the 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 by the ones that apply:

_____ Substance Abuse _____ Mental Health Information _____ Aids-related information

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to refuse to sign this authorization. If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information. I hereby authorize disclosure of protected health information as indicated above and acknowledge that I may receive a copy of this document upon request.

Clients Signature: _____ Date: _____

Legal Guardian's Name (if applicable): _____

Provider/Clinician Signature: _____ Date: _____