Phyllis Eddy, MA LMHC

2525 N. Ankeny Blvd. Suite 113
Ankeny, IA 50023
515-289-9136 (P)
515-289-9139 (F)

CONSUMER AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

This is an authorization for release of information about:	*Name of consumer*
Social Security Number	*Birth Date*
Name of Person or Organization	
Address	
For the purpose of:	

I understand that:

- I am authorizing the Phyllis Eddy, Center for Interpersonal Effectiveness, PC (CIE) and those identified above to release and exchange information.
- Unless I otherwise note, this authorization shall be reciprocal and will allow for information to be exchanged by oral, written and electronic means.
- This authorization will remain valid for one year from the dated signature or until: ______________________________
- My written notice to Phyllis Eddy will revoke this authorization, but will not cover information released prior to the revocation.
- This authorization shall not be a condition for services, unless it is required solely as part of the referral I have agreed to with the third party listed above to create protected health information.
- I have the right to access and copy my health information.
- I have the right to request to restrict disclosures of and to request to amend my health information.
- I have the right to receive a copy of the Phyllis Eddy's Notice of Privacy Practices.

INFORMATION BEING FORWARDED TO OTHERS SHALL BE SAFEGUARDED BY FEDERAL AND STATE LAW INCLUDING RESTRICTIONS ON THE FURTHER RELEASE BY THE RECEIVER OF THE INFORMATION RELEASED UNDER THIS AUTHORIZATION. I UNDERSTAND THAT THE CIE CANNOT ASSURE THAT THE RECIPIENT OF THE INFORMATION AUTHORIZED TO BE RELEASED WILL NOT REDISCLOSE THE RECEIVED INFORMATION AND THAT PARTY MAY NOT BE SUBJECT TO FEDERAL AND STATE LAWS REGARDING THE PRIVACY OF HEALTH INFORMATION.

INFORMATION AUTHORIZED INCLUDES:

To Phyllis Eddy

- ☐ Acknowledgement of Referral
- ☐ Social/Historical Past/Current
- ☐ Recommendations/Plans
- ☐ Progress
- ☐ Diagnostic Information
- ☐ Past/Current Assessment
- ☐ Medical Medication
- ☐ Legal Order/Findings
- ☐ Discharge Summaries
- ☐ Other:_________________________

To the Above Identified Party

- ☐ Acknowledgement of Referral
- ☐ Social/Historical Past/Current
- ☐ Recommendations/Plans
- ☐ Progress
- ☐ Diagnostic Information
- ☐ Past/Current Assessment
- ☐ Medical Medication
- ☐ Legal Order/Findings
- ☐ Discharge Summaries
- ☐ Other:___________________________

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY FEDERAL AND STATE LAW
I specifically authorize the release of information relating to the areas checked below:

	CIE	Identified Party
1. Mental Health	O	X
2. Substance Abuse	O	X
3. HIV-Related Information	O	X

____
Signature of Consumer or Legal Guardian **Date**

In order for the above information to be released, you must sign here AND to the left.

____
(Consumer Signature) **(Date)**

CIE Staff______________________________________

O Accepts Copy O Refuses Copy