



Pamela J. Davis, MA LMFT

2525 N. Ankeny Blvd. STE 113
Ankeny, IA 50021
515-289-9136 (P)
515-289-9139 (F)

106 2nd. St. SE
Altoona, IA 50009
515-967-1997 (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 Pamela J. Davis, MA LMFT 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 Pamela J. Davis, MA LMFT 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 Pamela J. Davis, MA LMFT'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 PAM J. DAVIS, MA LMFT, LISW 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 Pamela J. Davis, MA LMFT

- 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:

	Pamela J. Davis Identified Party	
1. Mental Health	0	0
2. Substance Abuse	0	0
3. HIV-Related Information	0	0

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

(Consumer Signature) (Date)

Pamela J. Davis, MA LMFT

Signature of Consumer or Legal Guardian Date

Accepts Copy Refuses Copy