AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

Iowa River Psychiatry and Counseling
585 West Cherry Street
North Liberty, IA 52317
PHONE 319-665-4724
*email: scottstuartmd@outlook.*com

Please complete this form in its entirety. Items not checked or blank spaces are assumed to be non-applicable or specifically not authorized for release. This release is invalid if it does not contain the patient's original signature and date signed or if it has expired as described below. Please keep a copy of this signed form for yourself.

Patient: _____ DOB: _____ SS#: _____

Person/Place Releasing Information: _____

Address: _____Phone: _____ _____

City: _____ State: _IA_ Zip: ____ Fax: _____ _____

Where Information Is To Be Sent: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Check here if both parties will be receiving and releasing information: ☐

Information Requested: ☐ Complete Records/Demographics ☐ Notes Other: _____

Purpose of Release: ☐ Continuity of Care ☐ Transfer of Care Other: _____

I understand that this will include information relating to (all three boxes must be checked):

☐ Substance Abuse (Alcohol/Drug)

☐ Mental Health (Includes Psychological Testing)

☐ HIV – Related Information (AIDS-Related Testing)

☐ I give my consent to fax and/or mail my records.

☐ I understand that Iowa River Psychiatry and Counseling may receive compensation for disclosure of information released pursuant to this authorization.

I give the named agency my permission to release only the information I have selected on this form to the individual(s) or agency(ies) I have named and only for the purpose I have checked. I understand that this release is valid up to the expiration date stated below, and I may refuse to sign this authorization at any time. Any revocation or refusal to sign this authorization will not effect my ability to obtain treatment, payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient, I have the right to access my treatment records. Copies of the records may be obtained with reasonable notice and payment for copying cost. I further understand that if the person or entity that receives the above specified information is not a health provider, health plan, or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations.

Signature of Patient/Legal Representative: _____ Date: _____

If not patient, print name: _____ Relationship: _____

Witness: _____ Expiration Date: _____