1810 W 8th Street Suite B
Cedar Falls, IA 50613
Phone: 319-505-5602
Fax: 319-409-9420

Release of Information

Patient's Legal Name_____ Date of Birth_____

By signing this form, I am allowing Integrative Minds, PLC to:
_____ Release Information
_____Obtain written and oral information via telephone, fax, electronic submission, or mail regarding the above named patient with the following individual or institution.

_____
Name of Person and/or Institution

_____
Address City State Zip Phone Fax

Check all information requesting to be disclosed:
_____ Psychiatric Evaluation _____ Laboratory Results
_____ Med/Progress Notes _____ Billing Information
_____ Psychological Testing/Assessments _____ Appointment Dates/Information
_____ Educational/Vocational Records _____ Discharge Summary
_____ Service Plan/ICP/Treatment Plan _____ Medical Records
_____ Other: Please Specify_____

This authorization is voluntary and will expire one year from the date that it is signed. If I choose to revoke this consent at a later date, I must present written revocation to: Integrative Minds, PLC. If this consent is cancelled, I understand that information may have been released prior to the revocation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) 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 Integrative Minds, PLC at the above address or phone number.

Confidentiality of the information is protected by Federal Law (42-CFR-Part 2) and the code of Iowa Chapter 228. Further disclosure is prohibited without specific consent from whom it pertains. General authorization is not sufficient for this purpose.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW
I understand that the information to be released may include information in the following categories unless I specifically deny the release

(initial any category **NOT** to be released).
_____Substance Abuse _____ Mental Health _____ HIV related information _____ Genetic testing

Patients 18 years or older, or legal representative, can authorize the release of mental health information.

_____ _____
Patient Signature Date

_____ _____ _____
Parent/Legal Guardian Signature Date Relationship