JCS | Journey Counseling Services
Walking with you in hope & compassion

6 Hawkeye Dr, Suite 105
North Liberty, IA 52317

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

Patient name:_____ Birthdate:_____

Social Security No:_____

I understand that the specific information to be disclosed includes the following and that I have a right to inspect the disclosed information at any time. I understand that I can revoke my consent in writing at any time, and if I do not revoke this consent, it will expire automatically one year after the date signed below.

I hereby authorize _____
(Name of individual or institution)

_____
(Address)

to disclose, exchange with, and deliver information to

_____
(Name of individual or institution)

_____
(Address)

for the purposes of evaluation, treatment planning, security, claims evaluation and payment. Further disclosure of this information to another party is unlawful and can result in criminal and civil penalties unless authorized by the client.

Initial	YES	NO	(Please place check mark under yes or no and initial beside each option)
_____	_____	_____	MENTAL HEALTH INFORMATION
_____	_____	_____	SUBSTANCE ABUSE(drug or alcohol)INFORMATION
_____	_____	_____	AIDS-RELATED INFORMATION
_____	_____	_____	DISCLOSURE necessary for claims processing/third party payor

I acknowledge that information released may include material that is protected by federal or state laws applicable to the diagnosis and treatment of substance abuse, mental illness, and AIDS-related conditions. I understand that my Records may be protected under the Federal Confidentiality Regulations (42 CFR Part 2) and, if so, cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Journey Counseling Services.. Revocation is effective upon receipt of such request.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/legal guardian Signature of Counselor