



Body & Soul Counseling Services

2728 Asbury Road, Suite 777 ~ Dubuque, Iowa 52001 ~ (563) 556-9642

Authorization To Release And Receive Information

Notice to Recipient of Information: This information has been disclosed to you from records whose confidentiality may be protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol/drug abuse patient.

I authorize Betty Heil, L.I.S.W. to release to/and obtain from the following:

AGENCY AND/OR PERSON: _____

ADDRESS: _____

REGARDING: _____

D.O.B.: _____ SSN: _____

NATURE OF INFORMATION TO BE RELEASED: Clinical Summary &/or Progress Notes.

THE PURPOSE FOR SUCH DISCLOSURE IS TO EXCHANGE INFORMATION.

Other purpose (if any): _____

I specifically authorize release of confidential information relating to:

Mental Health: YES NO HIV/AIDS related information: YES NO

Substance Abuse: YES NO Disclosure by fax authorized: YES NO

I understand the content and nature of the material I am releasing. I understand that I have the right to inspect the information which will be released through this authorization and that such an inspection will occur in a meeting with my therapist. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original. I understand that I may revoke this authorization by providing written revocation to the recipient named above and to the clinician. I also understand that any information which has been released prior to the revocation may be used for the purpose listed above. Unless otherwise specified, this consent will expire one year from the date of signing.

Signature

Signature of parent, guardian or authorized representative

Date

Signature of witness