CONSENT TO RELEASE AND EXCHANGE INFORMATION

☐ 2309 C St SW | Cedar Rapids, IA 52404
P: (319) 365-9164 F: (319) 365-6411

☐ 1030 5th Ave SE | Cedar Rapids, IA 52403
P: (319) 286-4545 F: (319) 368-3358

CLIENT NAME: _____ DOB: _____/_____/_____
First Middle Last

I hereby voluntarily authorize Tanager Place to disclose information to/from:

_____ **PURPOSE:** _____
Name of Person / Organization (that we're disclosing to/from)

_____ ☐ Treatment ☐ Personal Use
Address City State Zip

(_____) _____ (_____) _____ ☐ Insurance or Legal ☐ Other: _____
Phone / Fax Number

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the exchange and release of confidential information to or from the above individual(s) and/or organization. The information exchange may be in oral or written form. I understand that my authorization will remain effective from the date of my signature until _____/_____/_____ (MM/DD/YY), and that information will be handled confidentially in compliance with all applicable federal laws.

The purpose of this exchange of information is to ensure that pertinent information is available to Tanager Place staff for provision of the most comprehensive treatment possible. Services rendered, however, are not contingent upon the receipt or exchange of this information. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

I understand that I may review the disclosed information at the discretion of the sending person, institution or organization. I understand I can revoke my consent by writing to all concerned parties involved in the information exchange. However, any information already exchanged may be used as stated in this consent. Disclosure of this information carries with it the potential for unauthorized re-disclosure and once information is disclosed it may no longer be protected by federal privacy regulations.

I authorize the release of confidential information which requires specific consent under federal law.

Type of information: (Indicate Yes or No for all)

Mental Health*	☐ Yes	☐ No
Substance Abuse**	☐ Yes	☐ No
HIV / AIDS related Info.	☐ Yes	☐ No

Information to be released – from ____/____/_____ to ____/____/_____

☐ History and Physical ☐ Treatment Plan ☐ Reviews
☐ Progress Note(s) ☐ Lab / Pathology ☐ Consultations
☐ Immunization Record ☐ Discharge Summary ☐ Psychological Report
☐ Other: _____

Date: _____ / _____ / _____ **Printed Name:** _____
(Patient or Authorized Representative)

Witness: _____ **Signature:** _____
(Patient or Authorized Representative)

_____
(Relationship if other than Client)

* Only a person 18 years of age or older or a person's legal representative can authorize release of mental health information.
** Only the subject can authorize release of substance abuse information unless the subject is of such age and mental maturity that they are unable to authorize release.

COPY OF CONSENT GIVEN TO PARENT/GUARDIAN AND CLIENT_____ **OR DECLINED COPY** _____