Glen Haven Counseling Resources

Dr. Matthew Cooper, Dr. Daniel Earle

This information has been disclosed to you from records whose confidentiality may be protected by State and Federal law. If the records are so protected, Federal Regulation (42 CFR-Part 2) and Chapter 228 of the code of Iowa prohibits you from making any further disclosure of these records without the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. An unauthorized disclosure of mental health, substance abuse, and or AIDS/HIV related information is unlawful and may result in civil damages and/or criminal penalties. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

Client Name:_____
Client Date of Birth:_____
Release To/From:_____
Address:_____
_____
Phone/Fax Number:_____

I authorize _____Dr. Daniel Earle
_____Dr. Matthew Cooper

to _____ release _____ obtain the mental health information indicated below:

__Acknowledge Referral
__Treatment Plan/Diagnosis
__Psychiatric Evaluation
__Prior Psychiatric History
__Social History/Data
__Medical History
__Progress Notes
__Program Planning
__Current Assessment of Functioning
__Recommendations/Plans
__Psychological Testing Results
__Reason For Termination

__Other_____

The purpose of this disclosure is assisting in my:
__Evaluation
__Coordination of Services
__Treatment
__Program Plan
__Assessment

__Other_____

I understand the content and nature of the material I am releasing, and that I do not need to sign this form to receive services. I understand that I have the right to inspect the information which will be released through this authorization and that such inspection will occur in a meeting with my therapist or other mental health professional. A photocopy or exact reproduction of this signed authorization shall have the same effect as the original. I understand that I may revoke this authorization by providing a written revocation to Dr. Daniel Earle, Dr. Krista Brittain, Dr. Matthew Cooper, or Resa Eckhart, LMFT. I also understand that any information that has been released prior to revocation may be used for the purposes listed above. Unless withdrawn, this consent will expire one year from the date of my signature.

_____ Client Signature

_____ Witness

_____ Signature of Parent, Guardian or Representative (if applicable)

_____ Date

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