Premier Counseling Services, PLLC
2004 S St Aubin St, Suite 101
Sioux City, IA 51106-2457
712-870-1445(voice) 712-248-8866(Fax)

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name:
_____DOB:_____

I, the undersigned, do authorize Premier Counseling Services, PLLC, to exchange with:

_____

_____

the following information:

_____Social History ___Psych. Eval. ___Diagnosis ___ Progress Notes

_____Treatment Plan ___Closing Report __ C/D Eval ____Other

for the purpose(s) of evaluation, treatment, recommendations, coordination of services, legal proceedings, reimbursement, and/or other (specify):_____

_____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:
By initialing all applicable lines, I authorize the exchange of confidential information related to:

____Mental Health

____Substance Abuse (alcohol/drug abuse)

____HIV/AIDS-related information

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken, by giving written notice to Premier Counseling Services, PLLC. Disclosure of information may be oral or written and can include copies of reports. I understand that I have the right to review the disclosed information by contacting my therapist at PCS. This authorization will remain in effect for 12 months from the date this is signed or as follows:_____

_____

_____ _____
Signature of Patient **Signature of Parent or Legal Guardian**

_____

Date **Witness**

PROHIBITION ON FURTHER DISCLOSURE
This information is protected by Federal Regulation 42 CFR 2, which prohibits further disclosure (to a party not listed above) without the written consent of the patient, or as otherwise permitted by law or regulation. A general authorization for the release of information is not sufficient for these purposes. Unauthorized disclosure is unlawful and civil damages &/or criminal penalties may apply.