



Glen Haven Counseling Resources

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**

to release obtain the mental health information indicated below:

- | | |
|---|---|
| <input type="checkbox"/> Acknowledge Referral | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Treatment Plan/Diagnosis | <input type="checkbox"/> Program Planning |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Current Assessment of Functioning |
| <input type="checkbox"/> Prior Psychiatric History | <input type="checkbox"/> Recommendations/Plans |
| <input type="checkbox"/> Social History/Data | <input type="checkbox"/> Psychological Testing Results |
| <input type="checkbox"/> Medical History | <input type="checkbox"/> Reason For Termination |
| <input type="checkbox"/> 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 or Dr. Matthew Cooper. 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