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:

___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. 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 Unless withdrawn, this consent will expire one year from the date of my signature.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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