Kathryn H. Hedican LMHC, RPT, LLC
978 Home Plaza Waterloo, IA 50701
319-504-5740 * Fax 319

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client Name: _________________________________ Date of Birth: ____________________________

I voluntarily authorize Kathryn H. Hedican to:

___Exchange with ___Release to ___Obtain from the party indicated below:

Name: ____
Address: ____
Telephone: ____
Relationship: ____

I authorize the release/exchange of the following MENTAL HEALTH information: (check all that apply)

___Medical history
___Psychological history
___Assessment and diagnosis
___Progress notes
___Treatment plans
___Lab reports
___Medication and treatment records
___Summary of psychological testing
___Discharge summary
___Dates of service
___Educational/Vocational planning
___Psychiatric evaluation
___Other ________________________

The purpose for which the information may be used:

___Acknowledgment of referral
___Summary of previous treatment
___Treatment planning
___Termination of Service Notice
___Social history/data
___Educational/Vocational planning
___Progress report
___Continuity/Coordination of service
___Insurance/managed care review
___Other _________________________

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

I specifically authorize the release of information relating to:

1. Substance Abuse: YES * NO 2. HIV-Related: YES * NO

(Signature required both here and below)

_______________________________________ ___________________________ _____________
Signature of Consumer/Legally Authorized Relationship to Consumer Date

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I understand that I have a right to review the above disclosed information with my therapist or other mental health professional. I may revoke this authorization at any time, unless action has already been taken on it, by giving written notice to both recipient and Kathryn H. Hedican. Unless revoked, this authorization will expire on (specific date no more than one year from signature below): _____________

____ ____________________________ _____________
Signature of Consumer/Legally Authorized Relationship to Consumer Date

____ _____________
Signature of Witness/Requester of Information Date