New Leaf THERAPY
Dr. Valerie Stokes, LISW

Name: _____ Social Security #: _____

DOB: _____ Medicaid or Insurance #: _____

I authorize New Leaf Therapy LLC (Dr. Valerie Stokes) as well as the following individual or agency to share written and oral information, by telephone, fax, electronic data interchange, or by mail, regarding protected health information about my needs and the services I receive:

Name/Agency: _____

Address: _____

For the following reason: _____

_____

The information released or shared includes: (check all that apply)

_____ Psychiatric Evaluation
_____ Med Check Notes
_____ Initial Assessments
_____ Progress Notes
_____ Progress Summary
_____ Discharge Summary
_____ Social History
_____ Service Plan/ICP/Treatment Plan
_____ Annual Review
_____ Psychological Testing/Assessments
_____ Educational/Vocational Records
_____ Medical History and Records
_____ Re-release of 3rd Party Information (specify): _____
_____ Other (specify): _____

PURPOSE-The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or exact reproduction of this Authorization shall have the same effect as the original.

I understand that I may revoke my consent by writing to both the person giving the and the person receiving the information, but any information already released may be used as stated on this consent.

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

I specifically authorize the release of data and information relating to:

_____ Mental Health _____ Substance Abuse _____ HIV related information

Furthermore, I SPECIFICALLY AUTHORIZE disclosure of protected health information to all persons referred to in the authorization. The undersigned has a right to inspect the disclosed information and information being obtained from, disclosed to, and/or exchanged with at any time. This authorization shall be in effect for 12 months (or_____months) from the date it is signed, or if applicable, until the date of the final disposition of the conditional release or other court action in connection with which this consent is given {42 CFR 2.35 J(c)}. Also, the undersigned understands he/she may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon, and by giving written notice to _____.

I hereby authorize disclosure of protected health information as indicated above and acknowledge that I may receive a copy of this document upon request.

_____ _____

Client Signature Date of Signature

_____ _____

Parent/Legal Guardian Signature (if client is a minor) Date of Signature

*Only client 18 years or older, or legal representatives, can authorize release of mental health information. Only client, regardless of age, can authorize release of substance abuse information.

Confidentiality of this information is protected by Federal Law (42-CFR-Part2) and the code of Iowa Chapter 228. Further disclosure is prohibited without specific content from whom it pertains. General authorization is not sufficient for this purpose.