Robyn Rodenburgh, LMHC, RPT, IADC
142 Brookeridge Dr.
Waterloo, IA 50702
319-231-5871
Fax: 888-981-5029
robynrodenburgh@yahoo.com

Authorization for the release/exchange of information

I understand that my records may be protected under the Federal Confidentiality Regulations (42 CFR Part 2) and if so, cannot be disclosed without my written permission unless otherwise provided for in the regulations and/or under state specific provisions.
I understand that my records may contain information regarding my mental health, substance use or dependency, sexuality and may exchange these records to the parties named below.

_____
Client name DOB

_____
Address City State Zip Code

I authorize Robyn Rodenburgh, LMHC, to (please check and initial):

_____ Exchange with
_____ Release to
_____ Obtain from the party I have indicated below
Name:_____
Relationship:_____
Address:_____
City, State, Zip: _____
Phone Number: _____

I authorize the release or exchange of the following medical records and information (check all applicable):

___ All materials in record
___ Psychological History
___ Summary of psychological testing
___ Substance use, assessment, and treatment
___ Medication and treatment records
___ Attendance only
___ Other: _____
___ Medical History
___ Assessment and Diagnosis
___ Progress Notes
___ Treatment Plans
___ Discharge Summary
___ Only in an emergency

The information is required for (check one or more options):

___ Summary of previous treatment
___ Continuity of care
___ To involve a client's family/concerned person of treatment plan and progress
___ Insurance/managed care review (for justification of charges, quality of care, treatment progress, and or medical necessity)
___ Other: _____

I understand that the information or records listed above will not be used for any other purpose other than the intended use. The re-release of this information to parties other than those named above is prohibited. Further more, the records requested and all copies of the information will be destroyed or returned before or immediately after the date listed below.
I understand that I may revoke this authorization at any time, unless action has already been take on it, by giving written notice to the parties listed below.
This authorization automatically expires, unless otherwise provided by state law, on: _____

_____ _____ _____
Signature or client/legal guardian Relationship to client Date

_____ _____
Signature of minor Date

_____ _____
Signature of witness Date