Family
Wellness Associates

I, _____, Date of Birth is _____

Address: _____City/State/Zip: _____

By signing this form, I am AUTHORIZING:
Family Wellness Associates
1115 5th Street, Sioux City, Iowa 51101
To release or obtain written and oral information by telephone, fax, electronic data exchange or mail concerning the above-named patient with the following individual or agency:

_____
(Person or Title of Person or Organization)

Description of Information to be Disclosed: (Patient/Client should initial each item disclosed)

_____Whether the client is in treatment or not. Prior or current services.
_____Progress notes, family data/social history
_____Educational/ vocational
_____Prognosis (diagnosis, opinion of how treatment will benefit client, general peculiarities of case)
_____Brief statement regarding progress (client's participation, progress or lack of progress, cooperation)
_____Brief statement regarding relapse and frequency of relapse (cannot identify specific drugs)

Purpose:

_____Treatment planning & Coordination of care
_____Consultation with Primary Care Physician- Medication history, Medical history,
_____Consultation with other mental health provider/medication management
_____Two Way communication
_____ Collaboration between substance abuse and mental health providers at Family Wellness Associates.
_____Other _____

Specific Authorization for release of information: PROTECTED BY STATE OR FEDERAL LAW
I hereby specifically authorize the release of data and information relating to:
_____HIV/AIDS _____Mental Health _____Alcohol/Drug Abuse
Signature: _____

Signature of Client: _____ Date: _____

Signature of Provider: _____ Date: _____

This authorization expires on the following date: _____ or as otherwise indicated: _____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent expires automatically one year after this form or Specific date, event, or condition.