AUTHORIZATION FOR RELEASE OF PROFESSIONAL INFORMATION
(Authorization is valid for all Orchard Place branches)

Orchard Place/Child Guidance Center	Orchard Place Campus	Orchard Place/PACE Center
808 5th Avenue Des Moines, IA 50309 515-244-2267 515-244-1922 (fax)	925 SW Porter Avenue Des Moines, IA 50315 515-285-6781 515-287-9695 (fax)	620 8th Street Des Moines, IA 50309 515-697-5700 515-697-5701 (fax)

Client Name: _____ Client Birthdate: _____

I, the undersigned, do authorize and request _____
(name of individual/agency)

to release to Orchard Place information from _____ until one year from the date the authorization is signed.
(date)

- ☐ General Medical Care
- ☐ Mental Health
- ☐ Other _____
- ☐ Educational/Developmental Information
- ☐ HIV or AIDS Information/Diagnosis/Test Results

I agree that Orchard Place may release the following information to the above named individual/agency:

- ☐ General Medical Care
- ☐ Mental Health
- ☐ Other _____
- ☐ Educational/Developmental Information
- ☐ HIV or AIDS Information/Diagnosis/Test Results

The information being disclosed may be used only for the following purposes:

- ☐ Case Coordination and Treatment Planning/Communication
- ☐ Medication Decisions
- ☐ Other _____

I understand that I have the right to revoke this authorization at any time by giving written notice to both parties. Any revocation will not affect any release of information occurring prior to receipt by both parties of the revocation. I understand that my revocation or refusal to sign this authorization will not affect my ability to obtain health care.

I understand that I have the right to inspect the information disclosed pursuant to this authorization at any time, subject to such reasonable conditions as may be established by Orchard Place.

I acknowledge that I have carefully read this authorization in its entirety as completed, understand its contents and have signed this authorization as my own free act. I further acknowledge that I have been offered a completed copy of this authorization. A photocopy or exact reproduction of this authorization shall have the same effect as the original.

If this authorization is executed by a person other than the client, that person represents and declares that he/she is the legal representative of the client and has the authority to execute this authorization on behalf of him/her.

Prohibition on Redisclosure: This form does not authorize disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by Federal Law and by state law for mental health records, Federal requirements and State requirements (Iowa Code Ch. 228, Iowa Code Ch. 125 and Iowa Code Sec 141A.9) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes.

Consent to Use & Disclose Health Information: I acknowledge that information to be released may include material that is protected by either state and/or federal law applicable to mental health information. My signature authorizes release of all information as specified above.

_____
(Signature of Client or Personal Representative)

_____
(Relationship)

_____
(Witness)

_____
(Date)