



FAMILY THERAPY &
RENEWAL CENTER

Full Heart Family Therapy and Renewal Center

515-705-0174

0. Release of Information

Authorization for Use and Disclosure of Protected Health Information

PERMISSION IS HEREBY GIVEN FOR:

Full Heart Family Therapy and Renewal Center, LLC,
1605 N. Ankeny Blvd. Suite 210 | 3200 Ingersoll Ave., Suite E
Ankeny, IA 50023 Des Moines, IA 50312

Full Heart Therapist's name:

- TO RELEASE INFORMATION TO THE FOLLOWING AGENCY/THERAPIST
- TO RECEIVE INFORMATION FROM THE FOLLOWING AGENCY/THERAPIST
- TO BOTH RELEASE AND RECIEVE INFORMATION TO AND FROM THE FOLLOWING AGENCY/THERAPIST

Name of agency/therapist/entity/person that permission to communicate with is granted:

Street Address:

City, State, Zip Code:

Phone Number:

CLIENT IDENTIFICATION

Client's Full Name:

Client's Date of Birth:

Client's Address:

Client's Mobile Phone Number:

PURPOSE OF REQUEST

- Request of client
- Billing/Insurance/Payment
- Treatment or Consultation
- Attorney/Legal
- Other

RECORDS TO BE PROVIDED

- Verbally/by phone
- Paper (hard copy)
- Electronically by fax only

Fax Number::

- Electronically by email (UNSECURED)

Email Address(es):

INFORMATION TO BE RELEASED

Covering the Periods of Health Care

From (Date)::

To (Date)::

TYPE OF INFORMATION TO BE RELEASED

- Assessments
- Discharge Summary
- Treatment Plan
- Appointment History
- Billing Statement
- Confirm session attendance
- Complete Clinical Record
- Other

Please Specify:

This information is being released for the following reasons

Please Explain:

STATEMENTS OF UNDERSTANDING

- I understand that this release may include information regarding drug and alcohol abuse and treatment, as well as psychological and psychiatric information.
- I understand that the information to be released is protected under state and federal laws that do not permit re-disclosure without my further consent.
- I understand that I may revoke this authorization at any time, except for information that has been disclosed as a result of this authorization prior to its revocation.
- This consent will expire 365 days from the date it is signed, unless otherwise requested.

CLIENT SIGNATURE OF CONSENT (or signature of Parent, Guardian, or Authorized Representative of Client):

DATE CONSENT IS GIVEN: