RELEASE OF INFORMATION CONSENT FORM

Client's Name: _____

I authorize Annie von Gillern and/or Abigail Sinclair (Rising Phoenix Wellness Center, LLC) to:

☐ Send ☐ Receive

The following information:

☐ Medical history and evaluation(s) ☐ Mental health evaluations
☐ Developmental and/or social history ☐ Educational records
☐ Progress notes, and treatment or closing summary
☐ Other: _____

To/From: _____

Phone: _____ **Email:** _____

Your relationship to client:

☐ Self ☐ Parent/legal guardian ☐ Personal representative
☐ Other: _____

The above information will be used for the following purposes:

☐ Planning appropriate treatment or program ☐ Case review
☐ Continuing appropriate treatment or program ☐ Updating files
☐ Determining eligibility for benefits or program
☐ Other: _____

Annie von Gillern
Clinical Director, MSW, LISW, JD

Abigail Sinclair
Psychotherapist, MSW, LISW

admin@rpwciowa.com

www.rpwciowa.com

4201 Westown Parkway, Suite 240,
West Des Moines, Iowa, 50266

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

_____
Printed Name

_____ ____/_____/20____
Signature Date

If the client is unable to sign:

_____
Witness Printed Name

_____ ____/_____/20____
Witness Signature Witness Date

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