FULL HEART
THERAPY

CONSENT TO RELEASE OR OBTAIN INFORMATION

Client Name: _____ **Client DOB**: _____

I, the undersigned, hereby authorize Full Heart Therapy, LLC by Andrea Nus, LMFT, member, to release/receive verbal and/or written information to/from:

_____ _____ _____

Name of person or entity information is to be released/received **Phone** **Fax**

_____

Address

The following written and verbal information may be included:

___ Medical: Evaluation or Treatment Reports

___ Psychiatric: Evaluation or Treatment Reports, Clinical Notes, Evaluation Results, Discharge Notes

___ Collaboration: Assessment reports, correspondence, summary reports, recommendations

___ Psychological: Evaluation and/or Treatment Reports, Clinical Notes

I understand by signing this General Authorization I am authorizing Full Heart Therapy, LLC by Andrea Nus, LMFT, member, to disclose my health information to the person(s) and/or entity listed above and any health information or other confidential information in the possession of the persons and entities listed above may be disclosed to Full Heart Therapy, LLC by Andrea Nus, LMFT, member. I understand I may revoke this authorization at any time by sending a written notice of revocation Full Heart Therapy, LLC by Andrea Nus, LMFT, member. I understand my revocation of this General Authorization will not affect a disclosure that Full Heart Therapy, LLC by Andrea Nus, LMFT, member, has already made under this authorization. I understand information used or disclosed under this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by Full Heart Therapy, LLC by Andrea Nus, LMFT, member's confidentiality rules. I waive any right of privacy that I may have in connection with the disclosures hereby authorized. I understand signing this is not a condition of receiving services. This authorization will expire 12 months from the date it was signed or on the specified date of ____/____/_____. I understand I may review the disclosed information by contacting Full Heart Therapy, LLC by Andrea Nus, LMFT, member.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND/OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT, HIV/AIDS-RELATED INFORMATION AND GENETIC INFORMATION:
I understand this will include information relating to the following categories unless I specifically deny the release.
(**Initial any category not to be released**)

_____Mental Health _____Substance Use _____HIV/AIDS _____ Genetic information including genetic test

_____ _____
Printed Name and Signature of Client Date

_____ _____
Printed Name and Signature of Doctor, Therapist, or Witness Date

222 Third Ave SE, Ste 240-10| Cedar Rapids, IA 52401| P: 319.423.8033|F: 319.483.6793| andrea@fullhearttherapy.com