**Child Psychiatry Associates, P.C.**

939 Office Park Rd., Suite 200 Telephone (515) 288-5570
West Des Moines, IA 50265 Fax (515) 440-3388

***Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below. A copy of this signed form will be provided to the patient.***

I hereby authorize Child Psychiatry Associates to (**check all that apply**):

_______ disclose (and/or) _______ receive _______ written records ______ verbal communication

The following information from the professional health records of: (**please initial**)

_____ Dr. Donner Dewdney _____ Dr. Kent Kunze _____ Dr. Thomas Hopkins _____ Deb Newman _____ Kim Comer
_____ Dr. Sheila Pottebaum _____ Diane Palmer _____ Judy Rinehart _____ Maggie McGill _____Molly Bruening
_____ Kathy Stoner Other ____________________

For the following patient:

Name: ________________________________________________________________________
**Last** **First** **MI** **Previous Name**

Birthdate: ___________________Social Security#:________________________

Telephone: (H) _____________________ (W) _________________ ___ (C) ____________ ___________

Address: ______________________________________________________________________________
**Street** **City** **State** **Zip**

This information is to be received from and/or disclosed to: (facility or individual)
_____________________________________________________________________ Fax Mail Pickup

Fax#/Address: ____________________________________________________________________

Covering Dates of Service:_______From: __________________ _____to:__________________________

For the Purpose of: ________________________________________________________________

I understand that this will include information relating to (**initial, if applicable**):

- ______ Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection.
- ______ Mental/Behavioral health service/psychiatric care.
- ______ Treatment for alcohol and/or drug abuse.

***If compensation will be received***: I understand that Child Psychiatry Associates, P.C. will receive compensation for its use/disclosure of the information released pursuant to this authorization. **Patient's initials**: _______

## Affirmation of Release:

I give ____________________________ (therapist's name) or the named agency permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have checked. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations or a business associated of these entities, the information described above may be re-disclosed and no longer protected by the regulations.

______________________________________________________________________________
Signature of the Patient/Guardian/Legal Representative Date Signed

______________________________________________________________________________
Signature of Witness/Relationship to Patient Date Signed

Expiration date :________________________( One year from date signed.)