Romans Ranch, Inc.
2197 210th Street
Boone, IA. 50036
Phone (515) 298-2202
RomansRanch.org

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

Name of Client ____. Date of Birth___/___/________

I, ______________________________________, hereby authorize Romans Ranch, Inc. (hereafter known as "provider") to disclose/exchange mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to therapist's diagnosis, of the client listed above to:

Name____

Address______________________________________ City____________________ State ____

Zip ______________ Phone_____-_____-_______ Fax_____-_____-_______

I am requesting this disclosure of information and records for the following purpose:
____At the request of the individual ____Other:________________________________

The specific uses and limitations of the types of health information to be released are as follows: (Check all that apply)
____Treatment Coordination ____Diagnostic Refinement ____Treatment Planning
____Other:____

Such disclosures shall be limited to the following specific types of information:
____Psychiatric diagnosis(es) ____Dates of Treatment ____Treatment Summary

This authorization shall remain valid until:____/____/_______(not to exceed one year)
____Initial Treatment Plan ____Full Treatment Record ____Other:___________________________

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider to be effective.

Provider shall not condition treatment upon my signing this authorization and I have the right to refuse to sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Iowa law may protect such information.

Signature of Client ____ Date____/____/_______

Signature of Legal Guardian,____

Relationship to Client _________________________________ Date____/____/_______

Revised 04/23/2021