THE UNIVERSITY OF IOWA

COLLEGE OF EDUCATION
The Connie Belin & Jacqueline N. Blank International Center for Gifted Education and Talent Development
600 Blank Honors Center
Iowa City, Iowa 52242-0454
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ASSESSMENT AND COUNSELING CLINIC
CONSENT TO RELEASE INFORMATION

Information Sent
Date
By

Patient Name _____ Birth Date _____

I, the undersigned, hereby authorize _____ of the Belin-Blank Center to ☐ disclose information, ☐ obtain information, or ☐ disclose and obtain information concerning the above named person to:

_____
Name of Person and/or Institution

_____
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

Check the information to be disclosed (include dates where indicated): Minimum necessary or specify:
☐ Medication list ☐ Problem list (Patient Summary List) ☐ Psychological report ☐ Verbal Exchange
☐ Most recent history and physical or specific date(s) _____
☐ Most recent discharge summary or specific date(s) _____
☐ Consultation reports from (doctors' names or clinic) _____
☐ Other, specify: _____

As per my request, reason for release of information: ☐ medical care ☐ legal ☐ insurance ☐ other (specify) _____

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to the Assessment and Counseling Clinic, 600 Blank Honors Center, The University of Iowa, Iowa City, IA 52242. I understand that any release that was made prior to my cancellation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized redisclosure and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Administrator of the Assessment and Counseling Clinic at the above address.

I understand that the Assessment and Counseling Clinic may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

I understand that the information to be released may include information in the following categories unless I specifically deny the release (initial any category not to be released).

Substance Abuse _____ Mental Health _____

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months) _____.

_____
Signature of Patient or Legal Guardian Date

_____
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

_____ _____
Relationship, If Not the Patient Witness Signature