Main Office:
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Parkersburg, IA 50665
319-346-1216
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MONARCH
THERAPY SERVICES, INC.

www.MonarchTherapyServices.com

Office Locations:
Waverly, Iowa
Waterloo, Iowa
Hampton, Iowa
Parkersburg, Iowa

AUTHORIZATION FOR THE RELEASE/EXCHANGE OF INFORMATION

- I understand that my records may be protected under the Federal Confidentiality Regulations (42 CFR Part 2) and if so, cannot be disclosed with out my written consent unless otherwise provided for in the regulations and/or under state specific provisions.
- I understand that my records may contain information regarding my mental health, substance use or dependency, sexuality and may contain confidential HIV/AIDS related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

Client Name | **Date of Birth** | **Chart Number**

Address | **City** | **State** | **Zip Code**

I authorize Monarch Therapy Services, Inc. to (please initial):

- _____ Exchange with
- _____ Release to
- _____ Obtain from the party I have indicated below

Name: _____
Relationship: _____
Address: _____
City, State, Zip: _____
Phone Number: _____

I authorize the release/exchange of the following medical records and information (check all applicable):

- ☒ All materials in record
- ☐ Medical History
- ☐ Psychosocial History
- ☐ Assessment and Diagnosis
- ☐ Progress Notes
- ☐ Treatment Plans
- ☐ Substance Use Assessment and Treatment
- ☐ Medication and Treatment Records
- ☐ Summary of Psychological Testing
- ☐ Discharge Summary
- ☐ Attendance Only
- ☐ Only in an Emergency
- ☐ Other

The information is required for (check one or more options):

- ☐ Summary of previous treatment
- ☐ Continuity of Care
- ☐ To keep clients parents aware of treatment
- ☐ Insurance/managed care review (for justification of charges, quality of care, treatment progress and or medical necessity
- ☐ Other

I understand that the information or records listed above will not be used for any other purpose other than the intended use. The re-release of this information to parties other than those named above is prohibited. Furthermore, the records requested and all copies of the information will be destroyed or returned before or immediately after the date listed below.
I understand I may revoke this authorization at any time, unless action has already been taken on it, by giving written notice to the parties listed below.
Select One (please initial):
_____This authorization is for short-term or one-time use and automatically expires, unless otherwise provided by state law, ninety (90) days from the date below.
_____This authorization is for ongoing use and automatically expires one year from the date below, unless otherwise provided by state law.

X _____ _____ _____
Signature of Client/Legal Guardian | Relationship to Client (if applicable) | Date

_____ _____
Signature of Minor Client | Date

X _____ _____
Signature of Witness or Requestor of Information | Date

White Copy – File Yellow Copy – Client (Rev. 1/13)

" We delight in the beauty of the butterfly, but rarely admit the changes it has gone through to achieve that beauty." Maya Angelou