5619 NW 86th Street, Ste 500, Johnston, IA, 50131 (515) 240-7285 candorconsultingiowa@gmail.com https://candoriowa.com

AUTHORIZATION FOR RELASE OF INFORMATION

I hereby authorize Erin Helleso MSW, LISW with Candor Recovery and Consulting, Inc. to disclose and obtain my individually identifiable health information as described below. I understand that this authorization will aid in requested treatment for myself or dependent. I understand I have the ability to revoke this release at any time in writing, but only the original signer of the release may do so.

I understand that this authorization does not expire unless specifically stated on this form, or until a minor reaches the age of majority, or at the request of the authorized signer, or upon the order of the court.

I choose to hereby designate a future date or specific event for when this release should expire (optional): ________________________________

I request information from the following treatment dates be shared (optional): ____

Patient Full Name	DOB	Phone	
Street Address	City	State	Zip

I am requesting that this information be shared between the following person/organization/provider:

Name	Phone	Email/Fax	
Street Address	City	State	Zip

The purpose of the use of this information is for the following reason(s): ___ Coordination of Care ___ Legal Counsel ___ Personal

___ Educational ___ DHHS ___ Court Order ___ Other: ____

I consent to this information to be shared via Verbal and Electronic means (email, fax, drive) and only when the following are marked will information be shared in addition to this. ___ Direct Pick-Up ___ Mail ___ Verbal Consultation Only

SPECIAL CONSENT FOR PRIVILEGED INFORMATION (***Please initial***): ___ Alcohol/Drug ___ HIV/AIDS ___ Mental Health

The following information may be shared pertaining to this consent:

___ Summary Abstract (Clinical Notes, Biopsychosocial Assessment, Care plans, Consultation notes, test results, discharge summary, session recordings/video).
___ Emergency Dept Report
___ Discharge Summary Only
___ Progress Notes (BHIS)
___ Billing Record/Financial/Insurance
___ Biopsychosocial Assessment Only
___ Provider Orders
___ Complete Chart (to include testing and externally obtained documents)
___ Lab Reports/SUD Testing
___ Care Plan Only
___ Consultation Purposes Only
___ Medication Reports
___ Email Communications
___ Other: ______________________________

I understand the record might not be complete, if it is a recent visit, and additional documentation could be added after submitting a request for a record exchange. I also understand that specific information regarding dependents/minors may not be allowed for release due to the therapeutic relationship and for their protection against abuse and/or exploitation in legal matters.

____ ______________________
Signature of Patient or Legal Representative if a dependent/minor *Date*

____ __________________________
Printed Name of Patient or Legal Representative *Relationship to Patient*

____
*Representative's Authority to Act for Patient (Guardianship, Adoption, Court Order, etc.) *Attach document*