Cornerstone Wellness Center, LLC
1523 S Bluff Blvd, Clinton, IA 52732
Phone: 563-243-6054/Fax:563-243-6828

Request and Authorization to Release Confidential Records and Information

Client Name:	DOB:
Parent/Guardian:	

I hereby authorize ___________________ at Cornerstone Wellness Center to release or obtain information concerning the above named client with:

Person/Agency Name:	Phone:
Address:	Fax:

The information being released will be used for the following purpose(s):

___ Coordination of Care ___ Treatment Planning ___ Transfer of Care ___ Litigation
___ Other:_______________________________

I authorize CWC to **release** the following:

___ Initial Assessment ___ Discharge Summary
___ Diagnosis ___ Medication
___ Treatment Plan ___ Progress Notes
___ Psychological Evaluations ___ Billing Records
___ Psychiatric Evaluations ___ Other:_____________

I authorize CWC to **obtain** the following:

___ Initial Assessment ___ Discharge Summary
___ Diagnosis ___ Medication
___ Treatment Plan ___ Progress Notes
___ Psychological Evaluations ___ Billing Records
___ Psychiatric Evaluations ___ Academic Records
___ Other: __________________

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:
I authorize the release of the information below, which requires specific consent:

Substance Abuse_____ Mental Health _____ HIV-related info _____

Client/Guardian Signature:_______________________________________ Date: __________________

Signature of Minor, if required: ___________________________________ Date: __________________

This release will expire one year from the date of signature, unless previously revoked or otherwise indicated here: _________________

Signature of Client/Guardian:____ Date: ___________________

Relationship if NOT the client: ____

Witness Signature: ____ Date: __________________

I understand that services may be denied to me if I refuse to consent to this release of information, *if and only if* the information is necessary for either the purpose of the service, or for skilled treatment. I have no other duty to consent to this release. I do release these records because I believe that they are necessary for the purpose given above. The information disclosed may be used for that purpose. I understand that any information that I have released will become part of the file of both parties, and may be redisclosed if I later release records from either party. I understand I may revoke this release at any time, by contacting either party named above, but any information already disclosed cannot be recalled. I authorize the sources named on this form to exchange information about the reasons for my referral, any relevant history or diagnoses, and other similar information that can assist in achieving the purposes of this disclosure. In consideration of this consent, I hereby release the source of the records from any and all liability arising from my giving this consent. I understand that I am allowed to inspect and copy the disclosed records at any time