Moxie Nova
THERAPY SERVICES

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Authorization For Release of Protected Health Information

Client Information

Name: _____ Address: _____

Phone: _____ Birthdate: _____ Social Security #: _____

Parent/guardian (if applicable): _____

Address and phone of parent/guardian: _____

Information Being Sent To/From *(one release per person or facility)*

_____ Name or Facility Name _____ Address _____ Fax Number	CHECK ONE: ❑ Send To ❑ Obtain From ❑ Send To & Obtain From	_____ Name or Facility Name _____ Address _____ Fax Number

Purpose of Disclosure *(mark all that apply)*

❑ Coordination ❑ Personal ❑Legal ❑ Healthcare ❑ Insurance ❑ Other: _____

I hereby authorize Moxie Nova, PLLC and the source named above to each exchange, disclosure, send and/or obtain the records listed which are marked/indicated in the boxes below:

❑ All records (full records disclosure)
❑ Admission and discharge summaries
❑ Medical assessments with diagnoses
❑ Progress reports
❑ Date and times of appointments
❑ Billing records
❑ Treatment/service plans
❑ Evaluation(s), reports, or treatment summary of progress
❑ A letter containing dates of treatment(s) and summary of care/treatment
❑ Other: _____
_____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION FURTHER PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of information related to (check all that apply):

❑ MENTAL HEALTH INFORMATION
❑ DRUG AND ALCOHOL INFORMATION
❑ HIV-RELATED INFORMATION
❑ GENETIC INFORMATION

_____ _____ _____

Signature of client or parent/guardian | Printed name | Date

This request/authorization is valid during the pendency of any claim or demand made by or on behalf of me/the client, and arising out of an accident, injury, or occurrence to me/the client. I understand that I may void this request/ authorization, except for action already taken, at any time by means of a written notification to Moxie Nova, PLLC revoking the authorization and transfer of information, but that this revocation is not retroactive. CFR Part 2 does permit me to revoke consent orally [42 CFR §2.31(a)(8),(c)(8)] regarding drug and alcohol related information until proper written notification can be obtained. If I do not void this request/authorization, it will automatically expire one (1) year from the signed date, unless otherwise specified:

_____

(date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent)

Medical records may be released without specific consent from the client to Iowa law 'for purposes of care coordination' if not otherwise restricted by federal law or regulation, or as otherwise defined in Notice of Privacy Practice available at www.moxienova.com

The potential for information disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and no longer be protected by federal law. In consideration of this consent, I hereby release the source of the records from all liability arising there-from.

I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these. If the client record is provided in an unencrypted format, Moxie Nova, PLLC cannot ensure the privacy of the information. Other formats may be considered depending on system constraints. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request and to receive a list of all entities that have received my information under a signed general designation.

I authorize all Moxie Nova, PLLC providers, staff, and associates to speak in written and/or verbal communication. with the person or facility named in this release of information. I understand this authorization is voluntary. That no service, treatment, eligibility, or payment will be denied to me/the client solely because I refuse to consent to this release of information, and that I am not obligated to release these records. The information disclosed may be used in connection with my/the client's treatment. I understand, however, that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state or federal law.

I agree that a photocopy and/ or fax of this form is acceptable and is to be considered as valid as the original, but it must be individually signed by me, the releaser, and a witness if necessary. I agree that an electronic signature is acceptable and is to be considered as valid as an original signature.

Signatures

_____	_____	_____
Signature of client or parent/guardian	Printed name	Date
_____	_____	_____
Witness Signature *(if client is unable to sign)*	Printed name	Date

❑ Copy for client or parent/guardian ❑ Copy for source of records ❑ Copy for recipient of records