VIRTUE MEDICINE

221 E. College St. Ste 212
Iowa City, Iowa 52240
Phone: 319-338-5190
Fax: 319-354-3718
www.virtuemedicine.com

Authorization to Release Confidential Records or Information

Client: _____, Date of Birth _____

Address:_____

_____**, at Virtue Medicine, P.C.** is hereby authorized to **release information** regarding the above named client from her records to the following **individual or entity**:

_____

Address:_____

_____

Phone: _____Email: _____ Fax: _____

for the following purpose(s):

❑ Medical evaluation, treatment, or care ❑ Management of Billing/Invoices ❑ Family/Next of Kin Safety Plan
❑ Coaching/Professionalism Coordination of Care ❑ Other: _____

The information to be disclosed is marked by an X, concerning the time between _____ and _____.

❑ Medical and mental health history and diagnostic evaluation(s) ❑ Medical progress notes and treatment plans
❑ Coaching summaries/care plans ❑ Other:_____

If a medical release, HIV-related and drug/ alcohol info will be released under this consent unless indicated here:
❑ Do not release HIV-related information ❑ Do not release drug and alcohol information.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. I release the source of the records from any and all liability incurred through release of my information. This request is entirely voluntary on my part. I understand that I may revoke this consent at any time except to the extent that action based on this consent has already been taken.

This consent will expire automatically **in 2 years**, or ❑ _____ from the date on which it is signed, unless revoked in writing. I agree that a photocopy of this form is valid, if signed by client or legal guardian.

_____ _____ _____
Signature of client Printed name Date

_____