I, _____ **authorize Central Iowa Therapy Solutions, LLC.** to release written and/or verbal information regarding my condition and treatment to the following person/agency:

_____

I, the undersigned, authorize

_____

to release written and/or verbal information regarding my condition and treatment to Central Iowa Therapy Solutions, LLC. This authorization is effective for 12 months from the date on which it is signed. I understand that I may refuse to sign this authorization or revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving notice to the healthcare provider.

I understand that records released will contain information regarding my mental health treatment and may include information regarding any drug and alcohol treatment/abuse. I understand that the confidentiality of these records will be protected in compliance with state and/or federal law. I specifically authorize the release of confidential information relating to the following.

Information being requested or disclosed is related to:
_____ Mental Health _____Substance Abuse

- **I understand that I have the right to inspect the information to be disclosed upon proper notification to and under appropriate conditions established by Central Iowa Therapy Solutions, LLC.**
- **I understand that my health care and payment for my health care will not be affected if I do not sign this form.**
- **I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected from federal privacy regulations.**
- **I understand this authorization is voluntary.**

This information is being requested or disclosed for the purpose of:

_____

_____ _____
SIGNATURE **DATE**

_____ _____
WITNESS **DATE**

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