ITERUM MENTAL HEALTH SERVICES, LLC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. CLIENT INFORMATION

Client's Full Name	Date of Birth	Phone
Address, City, State, ZIP	**Email (optional)**	

2. AUTHORIZATION

I, _____, authorize Iterum Mental Health Services, LLC ("Iterum") and its clinicians to share or obtain my health information as indicated below.

Direction (select one):

☐ DISCLOSE — Iterum may release my information TO the person/organization named below

☐ OBTAIN — Iterum may request and receive my information FROM the person/organization named below

☐ EXCHANGE — Iterum and the person/organization named below may share information with each other

3. PERSON / ORGANIZATION

Name / Organization	Relationship to Client (e.g., physician, school)
Address, City, State, ZIP	**Phone / Fax / Secure Email**

4. INFORMATION TO BE SHARED (select all that apply)

☐ Intake / assessment summary	☐ Medication information
☐ Diagnosis and treatment plan	☐ Discharge / termination summary
☐ Progress summary or treatment summary	☐ Medical or school records received from others
☐ Attendance and appointment dates	☐ Entire clinical record, excluding psychotherapy notes
☐ Psychological or psychoeducational testing reports	☐ Other (specify): _____

Limits: Psychotherapy notes (a clinician's separate process notes) are NOT covered by this form and require their own separate written authorization under HIPAA. If you want to include records related to substance use disorder treatment (42 CFR Part 2), or any other specially protected information, please list them specifically under "Other."

5. PURPOSE (select all that apply)

☐ At the client's request	☐ School or educational planning
☐ Coordination of care / treatment planning	☐ Legal or court-related request
☐ Continuity of care or referral	☐ Case consultation or review
☐ Insurance, billing, or payment	☐ Other (specify): _____

6. EXPIRATION

This authorization expires on ____ / ____ / _____, or upon the following event: _____. If neither is filled in, it expires 180 days after the date signed.

7. CLIENT RIGHTS AND ACKNOWLEDGMENT

- My signature is voluntary. Iterum will not refuse or condition my treatment, payment, or eligibility for services on whether I sign.
- I may revoke this authorization at any time by giving written notice to Iterum. Revocation will not undo any disclosure already made in reliance on it.
- I understand that information released under this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy rules (HIPAA, 45 CFR Parts 160 and 164) if the recipient is not a covered health care provider or plan. Records covered by 42 CFR Part 2 are subject to additional protections, and state law may also apply.
- I have the right to review the information to be shared and to receive a copy of this signed authorization.
- I have read this form, understand it, and have been told what information will be shared, with whom, and for what purpose.

Client Signature	**Date** ____ / ____ / _____
Parent / Legal Guardian / Personal Representative Signature (if applicable) Printed name and relationship / authority: _____	**Date** ____ / ____ / _____
Witness or Staff Signature (optional)	**Date** ____ / ____ / _____

If signing as a legal guardian or court-appointed representative, please attach documentation of your authority.

OFFICE USE Date received: _____ Identity verified: ☐ Copy given to client: ☐ Staff initials: _____ Scanned to chart: ☐