EVEREST INSTITUTE, LLC

2500 82ND PLACE, DES MOINES, IA 50322
Phone: 515-412-5112
Fax: 515-412-5123

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name _____ Birthdate _____/_____/_____

Address_____

I authorize the following parties
   1) Everest Institute, LLC

2)_____
     NAME   ADDRESS   TELEPHONE

…..to disclose the information initialed below from my medical records:

Please initial all that apply:

____ Discharge Summary	____ History and Physical
____ Social History	____ Mental Health/Substance Abuse
____ Laboratory, X-Ray, EKG	____ Consultation
____ Treatment Status	____ Emergency Contact only
____ Billing: Send Statement to: _____	____ Other (please specify) _____

The information is being requested for the following purpose(s):

_____

_____

I understand that I may revoke this authorization by providing a written revocation to the parties named above at any time. I also understand that any information which has been released prior to the revocation may be used for the purposes listed above. This authorization is effective for

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Please initial one of the following: _____ **twelve months**   _____ **indefinitely until revoked**

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from the date on which it is signed. I understand that I may have a right to inspect disclosed information at any time and that such inspection will occur in a meeting with a member of the professional staff.

I acknowledge that the information to be released may include material that is protected by state and/or federal law applicable to either mental health or substance abuse or both. My signature authorizes release of all such information

_____   _____
Signature of Patient or Patient's Authorized Representative   Date

_____
If authorized Representative. Relationship to Patient

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of Medical Information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for substance abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa code ch. 22) prohibits further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other Information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of substance abuse or mental health Information.