

**ADOPTION & ATTACHMENT TREATMENT CENTER
OF IOWA**

800 Webster Street Iowa City, IA 52240
Ph: 319-338-2722 Fax: 319-338-7758

Client Name: _____
SS# _____ Date of Birth _____

Party 1: AATC Party 2: Psychiatrist _____
800 Webster Street Address _____
Iowa City, IA 52240 _____

The purpose of this release is _____
_____.

I, the undersigned, hereby authorize regular exchange of information and/or copies of the following documents to be transferred between "Party 1" and "Party 2" subject to limitations as follow:

Transfer from "Party 1" to "Party 2" Yes _____ No _____
Transfer from "Party 2" to "Party 1" Yes _____ No _____

This information will include:

____ Treatment Plan & Reports ____ Medical & Psychiatric Reports
____ Reports to Third Party Payers ____ Educational Reports/Testing
____ Psychological Testing ____ Referral for Services
____ Discharge Summary ____ Intake Evaluation/Assessments

Other _____

I specifically authorize the release of information regarding the following:

Mental Health (includes psychological testing) Substance Abuse
 HIV related information

I understand that I may revoke in writing the consent granted by this form by sending notice to "Party 1" and "Party 2." I understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights of confidentiality. I understand that I have the right to review materials to be released at any time. This release of information will be valid for one year from the signed date below.

I fully understand all the above information and my consent on this form is freely given.

Signature of Client/Parent or Guardian Date

Witness Date

(Revised 5/9/06 C.P.)

