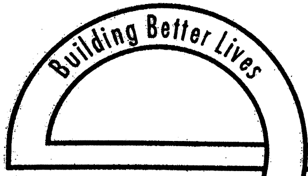


MIDWEST CHRISTIAN SERVICES

Authorization to Release Professional Information

1) All blanks are to be filled out prior to your signing.
2) Signing this is not required as a condition for treatment.
3) Sign this release only after:
   a) a specific request for the information has been made.
   b) you understand the release of information is in your best interest.
   c) you fully understand the limitations of this release.

I authorize Midwest Christian Services (4509 20th Ave., Peterson, Ia.) to release professional information to: Dr. Menke ______________________________

____

in regard to services rendered to:

Name: ______________________________

Date of Birth: ______________________________

for the purpose of:

Dental health ______________________________

____

Specific information to be released via telephone, verbally or written report will consist of: (Please check appropriate line)

____ Social History
____ Treatment Plan
____ Progress Reports
____ Individual Therapy Summary
_X_ Other (Please specify) Medical information

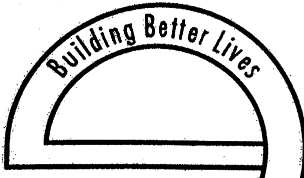
____ Group Therapy Summary
____ Family Therapy Summary
____ Discharge Summary / Recommendations

____

I understand I have the right to see this information at any time. I can revoke my consent by writing to both the person giving and the person receiving the information. But any information already released may be used as stated on this consent. This release is valid for a period of NINETY (90) DAYS past the date of discharge. This consent is not automatically renewable. It expires automatically at the end of the period specified unless revoked sooner. I have read this release form, or it has been read to me and I understand its consent.

Witness: ______________________________
Date: ______________________________

Signature: ______________________________
Relationship: ______________________________
Address: ______________________________
Date: ______________________________



MIDWEST CHRISTIAN SERVICES

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   c) you fully understand the limitations of this release.

I authorize Midwest Christian Services (4509 20th Ave., Peterson, Ia.) to release professional information to: Dr Veit

in regard to services rendered to:

Name: ______

Date of Birth: ______

for the purpose of:

Medical

Specific information to be released via telephone, verbally or written report will consist of: (Please check appropriate line)

____ Social History
____ Treatment Plan
____ Progress Reports
____ Individual Therapy Summary
____ Group Therapy Summary
____ Family Therapy Summary
____ Discharge Summary / Recommendations
_X_ Other (Please specify) Medical information

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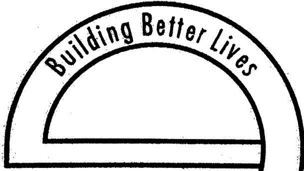
Witness: ______
Date: ______

Signature: ______
Relationship: ______
Address: ______
Date: ______



MIDWEST CHRISTIAN SERVICES

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    c) you fully understand the limitations of this release.

I authorize Midwest Christian Services (4509 20th Ave., Peterson, Ia.) to release professional information to: Vision Care ________________

in regard to services rendered to:
Name: ________________
Date of Birth: ________________
for the purpose of: Vision health

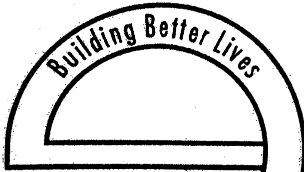
Specific information to be released via telephone, verbally or written report will consist of: (Please check appropriate line)

____ Social History
____ Treatment Plan
____ Progress Reports
____ Individual Therapy Summary
____ Group Therapy Summary
____ Family Therapy Summary
____ Discharge Summary / Recommendations
X Other (Please specify) Medical information

I understand I have the right to see this information at any time. I can revoke my consent by writing to both the person giving and the person receiving the information. But any information already released may be used as stated on this consent. This release is valid for a period of NINETY (90) DAYS past the date of discharge. This consent is not automatically renewable. It expires automatically at the end of the period specified unless revoked sooner. I have read this release form, or it has been read to me and I understand its consent.

Witness: ________________
Date: ________________

Signature: ________________
Relationship: ________________
Address: ________________
Date: ________________



MIDWEST CHRISTIAN SERVICES

Authorization to Release Professional Information

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    c) you fully understand the limitations of this release.

I authorize Midwest Christian Services (4509 20th Ave., Peterson, Ia.) to release professional information to: Spencer Psychiatric & Counseling Services

in regard to services rendered to:

Name: ____________________

Date of Birth: ____________________

for the purpose of:

Medication management and counseling

Specific information to be released via telephone, verbally or written report will consist of: (Please check appropriate line)

- X Social History
- X Treatment Plan
- X Progress Reports
- X Individual Therapy Summary
- X Other (Please specify) Medical information
- X Group Therapy Summary
- X Family Therapy Summary
- X Discharge Summary / Recommendations

I understand I have the right to see this information at any time. I can revoke my consent by writing to both the person giving and the person receiving the information. But any information already released may be used as stated on this consent. This release is valid for a period of NINETY (90) DAYS past the date of discharge. This consent is not automatically renewable. It expires automatically at the end of the period specified unless revoked sooner. I have read this release form, or it has been read to me and I understand its consent.

Witness: ____________________

Date: ____________________

Signature: ____________________

Relationship: ____________________

Address: ____________________

Date: ____________________

Authorization to Release Professional Information

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    a) a specific request for the information has been made.
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    c) you fully understand the limitations of this release.

I authorize Midwest Christian Services (4509 20th Ave., Peterson, Ia.) to release professional information to: Plains Area Mental Health

in regard to services rendered to:
Name: ____________________
Date of Birth: ____________________
for the purpose of:
LPHA assessments

Specific information to be released via telephone, verbally or written report will consist of: (Please check appropriate line)

- X Social History
- X Treatment Plan
- X Progress Reports
- X Individual Therapy Summary
- X Other (Please specify) Medical information
- X Group Therapy Summary
- X Family Therapy Summary
- X Discharge Summary / Recommendations

I understand I have the right to see this information at any time. I can revoke my consent by writing to both the person giving and the person receiving the information. But any information already released may be used as stated on this consent. This release is valid for a period of NINETY (90) DAYS past the date of discharge. This consent is not automatically renewable. It expires automatically at the end of the period specified unless revoked sooner. I have read this release form, or it has been read to me and I understand its consent.

Witness: ____________________
Date: ____________________

Signature: ____________________
Relationship: ____________________
Address: ____________________
Date: ____________________