

TURNING POINT PSYCHOTHERAPY ASSOCIATES, LLC
RELEASE OF INFORMATION

Effective One year FROM: _____ TO: _____

CLIENT'S NAME (Print): _____ DOB: _____

THERAPIST NAME (Print) _____

I AUTHORIZE *TURNING POINT PSYCHOTHERAPY ASSOCIATES, LLC* TO RELEASE INFORMATION TO OR OBTAIN INFORMATION FROM:

Specific Organization/Person: _____

Address: _____

INFORMATION THAT MAY BE RELEASED:

() Mental Health/Physical Information: () Presence and Progress in Treatment () Assessments () Diagnoses
() Tx/Recovery Plans () Psychiatric Summary () Medication Records
() Demographic Information

Other: _____

**REASON: () Provide continuity of care () Personal Use () Legal Purposes () Social Security/disability
() Insurance/Managed Care () Other _____**

DATES OF SERVICE: FROM _____ TO _____

I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law.

- 1) review and understand the Notice of Privacy Practices;
- 2) this authorization is subject to revocation at any time, except to the extent that action has been taken in reliance on the authorization;
- 3) inspect and receive a copy of the material to be released;
- 4) request restrictions on how my health information is used and disclosed; and
- 5) receive a copy of this authorization and the Notice of Privacy Practices

This form has been fully explained and I certify that I understand its contents. I understand that (agency) may not condition treatment on obtaining this consent/authorization from me.

Participant's Signature or Oral Consent when physically unable to sign
"I understand the nature of the release and freely give oral consent"

Date

Signature of Authorized Person in lieu of Participant
() Power of Attorney; () Guardianship Order

Date

Witness Signature

Date

Oral Consent/Witness Signature

Date