5 Warren Street, Suite 209
Phone: (518) 338-3117
Fax: (518) 831-5944

Release of Information

Name:_____DOB:_____

I do hereby consent to Turning Leaf Counseling Services to obtain information and/or records from and release information and/or records to:

_____

_____
(Address)

_____
(Phone) (Fax)

I authorize the following information to be exchanged:
• Presence in treatment (including admission/discharge dates)
• Psycho social assessment including diagnosis and mental status
• Description of treatment, progress and prognosis
• Medical history

This information is needed for the following purpose(s): To facilitate assessment, evaluation/ treatment and/or to coordinate treatment with other providers.

I understand that this authorization will expire one year from the date signed.

I understand that the above information is protected by Mental Hygiene Law 33.13 governing confidentiality of clinical records and/or by Federal Regulation 42 CFR, Part 2 governing confidentiality of Alcohol and Drug Abuse Records and cannot be disclosed without my written consent unless otherwise provided for in the law or regulations. I understand that I need not consent to the release of information in order to obtain services. I choose to do so willingly and voluntarily for the purpose(s) stated above. I understand that I may revoke this consent, in writing, at any time except to the extent that action has been taken in reliance on my consent. Redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization. I understand that this information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____ _____
(Client signature) (Date)

_____
(Parent or Guardian signature) (Date)

_____
(Witness signature) (Date)