



## Authorization to Release Psychiatric Records

Patient Name <i>Thomas Tracey</i>	Birth Date [REDACTED]
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I hereby authorize the following release:

ONE WAY: ☐ Client Initials

Turning Point Counseling, its agents, employees, or servants may disclose my psychiatric and/or psychological records and information obtained in the course of my diagnosis and treatment at this facility to:

Name <i>Bruce Williams</i>	Agent/Facility/school/physician <i>Elder, OC church of Christ</i>
Street Address	Phone ( ) [REDACTED]

MUTUAL EXCHANGE: ☒ Client Initials

Who may, in turn, release psychiatric and/or psychological records and information to Turning Point Counseling.

Personal contact, including phone calls and face-to-face meetings, may be initiated by either party when deemed necessary, within the time-frame specified.

Purpose(s) of Release

*to describe general nature of therapy, opinions of progress made, recovery strategies, discuss effectiveness of current church policies compared to therapeutic approach, etc.*

Such disclosures shall be limited to the following specific information.

- |                                                        |                                                               |                                                         |
|--------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Discharge Summary             | <input type="checkbox"/> Psychiatric history & Medical Status | <input type="checkbox"/> Lab Reports                    |
| <input type="checkbox"/> Progress notes & Brief Review | <input type="checkbox"/> Result of psychological tests        | <input type="checkbox"/> Education Assessment & Reports |
| <input type="checkbox"/> _____                         |                                                               |                                                         |

This consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance thereon and if not earlier revoked it shall terminate on Oct 31, 2017.

Release or transfer of the disclosed information to any person or entity not specified herein is prohibited by law. An additional consent must be obtained for further transfer or information.

I understand that I have the right to receive a copy and this authorization if I so request. (A copy is valid as the original).

I am fully aware that certain state and federal statutes and regulations require that I voluntarily sign this document before Turning Point Counseling can release any records, and that I may refuse to sign my signature, but in that event the records cannot and will not be released by the Turning Point Counseling. I free both above named parties of any liabilities if ever I revoke my decision to release the data.

Patient Signature <i>Tom Tracey</i>	Date <i>8/18/17</i>	Witness Signature	Date
Parent/Guardian/Responsible Party Signature	Date	Therapist/Physician Signature	Date