Turning Leaf Counseling

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Request for Records Form

Authorization for release or request of medical records:

Patient Name_____ Date of Birth ___/___/_____

E mail Address_____

I authorize *Turning Leaf Counseling, Inc* to release, disclose, or request confidential health information about me, by releasing or requesting a copy of my medical records, a summary or narrative of my protected health information, or verbally to the individual or organization listed below.

I am requesting that my medical records be released to:

Name: _____

Address: _____City: _____State_____Zip_____

Phone #_____Fax: _____

Please release the following information:

___ Evaluation/Assessment

___ Treatment Plan

___ Other_____

_____ _____

Signature or Individual's Legal Representative Date