Turning Leaf Counseling and Education Center

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CONSENT FOR DISCLOSURE/COMMUNICATION

Patient Name_____ SS_____-_____- _____ DOB____/____/____

Phone Numbers (Home)_____ (Work)_____ (Other)_____

❑ **This authorizes Turning Leaf Counseling to request information from**:
❑ **This authorizes Turning Leaf Counseling to communicate with:**

Name/Organization_____ Contact_____

Address_____

City_____ State_____Zip_____Telephone#:_____

Please release the following information (check all that apply):

❑ Admission Summary
❑ Discharge Summary
❑ History and Physical Exam
❑ Consultation Reports
❑ Hospital /Clinic Notes
❑ Treatment Summary
❑ Diagnosis
❑ Psychological Testing- Raw Data
❑ Psychological Testing-Interpretation
❑ Other(specify)_____
_____

For the following date(s) of treatment or condition: _____
(specify dates of treatment or condition)

This information release is being requested for the following purpose:

❑ Diagnosis & Evaluation
❑ Treatment Coordination & Planning
❑ Personal use
❑ Continued care by another provider
❑ Insurance claim purposes
❑ Other_____

- All records pertaining to psychiatric/ mental health, chemical dependency and/or AIDS/HIV related illness/ testing will be released unless otherwise indicated by a checkmark here: _____
  Please indicate any restrictions. (Specify _____ _____
- I understand I may revoke this authorization by written request at any time to the address checked at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date of my signature, or a lesser period of time as specified here: _____. The expiration period noted here may exceed one year only in certain situations as specified by law.
- I understand there may be a retrieval and copy charge assigned with the release.
- I understand that once information is released pursuant to this authorization, Turning Leaf Counseling & Education Center cannot prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid. A copy that has not been altered will be considered as valid as an original.
- Turning Leaf Counseling & Education Center will not condition treatment on my signing this authorization.

_____ _____ _____

Signature of Patient/ Authorized Person
(If authorized person is signing, please also print name)

Authorized Person's authority to sign
(Parent, Guardian, Power of Attorney, etc.)

Date

Reason patient is unable to sign: ❑ Minor ❑ Deceased ❑ Other:_____