RELEASE OF CLINICAL INFORMATION

As required by Section 2.32(a), Prohibition on disclosure: Rules: "This information has been disclosed to you from records protected by The State and Federal confidentiality rules (ORC 5122.31) (ORC 3701.243), (42 CFR Part 2). The rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Information to be released to:

Name of Person/Organization:_____

Street Address:_____

City, State, Zip: _____

Telephone: _____

Fax: _____

Name of Client: _____

Date of Birth: _____

INFORMATION TO BE _____ Disclosed and/or ____ Received

___ Psychotherapy Notes	_____ Diagnostic Assessment	____ Psychological Testing
___ Treatment Plan	_____ Inpatient/Outpatient Records	____ Lab Results/Drug Screens
___ Histories/Exams	_____ Academic Records	____ Teacher's Observations
___ Hospitalization Records	_____ Discharge Summary	____ Review of Summary Notes
___ Prior test results	_____ Other: _____	
	_____	

This information may include any psychiatric records related to emotional illness and information regulated by federal public law 93-282 concerning confidentiality of alcohol and drug abuse patients. This information may include any records documenting the diagnosis and/or treatment of AIDS, ARC, HIV positivity, and other related diseases.

Authorization to Release Information: I hereby authorize TURNING POINT PSYCHOTHERAPY AND ASSESSMENT, LLC to disclose and/or receive information checked above regarding this client to the above named person and/or organization for the reason shown below. I understand that the information disclosed is protected by law and may not be redisclosed without my written authorization or as otherwise authorized by law; however, I understand that TURNING POINT PSYCHOTHERAPY AND ASSESSMENT, LLC cannot control the recipient's use of the information. I understand that this Authorization to Release Information may be revoked by the client or their legal guardian, in writing. This Authorization to Release Information expires in 180 days from its signing unless another expiration date is indicated, which is agreed to by the client. I have the right to shorten or lengthen this authorization period at any time.

REASON FOR REQUEST: _____

_____

_____

Signature of Client/Guardian Relationship Date

_____

Signature of Witness Date