TURNING POINT
COUNSELING SERVICES
WHERE GROWTH BEGINS

Authorization For Release Of Confidential Information

Client Name_______________________________ Client Name________________________________

I authorize Turning Point Counseling Services LLC and the persons or entities listed below, or their representatives, to mutually release, exchange and disclose my health information.

I have received and reviewed the Notice of Privacy Practices.
I understand that only authorized representatives of Turning Point Counseling Services LLC may ask me to sign this authorization.

I understand that by signing this general authorization I am authorizing Turning Point Counseling Services LLC to disclose my health information to the persons and entities listed below and that any health information or other confidential information in the possession of the persons and entities listed below may be disclosed to Turning Point Counseling Services LLC. My health information includes, without limitation, any records, reports, test results, opinions, assessments and any other information relating to medical, emotional, educational, mental, social, spiritual or psychological condition. Disclosure may also be made to describe my condition and progress and to discuss treatment.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to Turning Point Counseling Services LLC. I understand that my revocation of this general authorization will not affect a disclosure that Turning Point Counseling Services LLC has already made under this authorization.

I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by Turning Point Counseling Services LLC confidentiality rules.

I waive any right of privacy that I may have in connection with the disclosures hereby authorized.

For parents of minors receiving services: I authorize ________________________________ to receive services provided by Turning Point Counseling Services LLC. This release authorizes any necessary psychological and/ or psychiatric evaluation and treatment or release of any information regarding minor to disclosed persons or entities. My signature below indicates that I agree and give consent to the above services. I also understand that parental participation in one or more of the following ways may be required: assessment, individual counseling, marital counseling, family counseling, parenting skills training or group counseling.

This authorization is only valid until ________________ (fill in date) or until six months after my file is closed by Turning Point Counseling Services LLC.

Name:	Address:	Phone:	Client's Initials:
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Name:	Address:	Phone:	Client's Initials:
Name:	Address:	Phone:	Client's Initials:
Name:	Address:	Phone:	Client's Initials:
Name:	Address:	Phone:	Client's Initials:

Signatures:

Client's Signature:	Date:	Client's Signature:	Date:
Print Name:	Date:	Print Name:	Date:
Parent/Guardian Signature:	Date:	Parent/ Guardian Signature:	Date:
Witness:	Date:	Witness:	Date: