TURNING POINT COUNSELING SERVICES

Turning Point

AUTHORIZATION TO RELEASE INFORMATION

To release to: Name:_____

Relationship:_____

Address:_____

City:_____State:_____Zip:_____

Phone #:_____Fax#_____

I authorize: Turning Point Clinical Staff
315 5th Ave
Fairbanks, AK 99701
(907)374-7776

I authorize: Name:_____

Relationship:_____

Address:_____

City:_____State:_____Zip:_____

Phone #:_____ Fax #:_____

To release to: Turning Point Clinical Staff
315 5th Ave
Fairbanks, AK 99701
(907)374-7776
fax 1-800-988-1650

Please place your initials on the line(s) that describe the types of information you are authorizing to be released.

_____Assessment, Diagnostic Reports and/or Labs
_____Treatment Plan
_____Treatment Summary
_____Case Notes
_____Discharge Plan
_____Psychiatric Evaluation Reports
_____Psychological Testing Information
_____ Substance Use Disorder Assessment and Treatment History
_____ Scheduling & Finance
_____ Verbal to Coordinate Care
_____Other (specify):_____

Please initial on the line that describes your intent for the duration of this written Authorization

_____This written Authorization shall remain valid for one year from the date of my signature below.

_____This written Authorization shall expire upon completion of this single request.

_____This written Authorization shall remain valid until an ascertainable event has been met.

Ascertainable Event:_____

This information will be used for my evaluation, treatment, follow-up care, and/or to determine benefits payable and claim insurance for treatment services.

I hereby release both the above parties from any liability that may result from furnishing the information released. I understand that I may revoke this written authorization at any time except to the extent that action has been taken in reliance on it and that; in any event, this consent shall expire 90 days after completion of services provided by the Clinical Staff of Turning Point Counseling Services.

Redisclosure is prohibited. Federal regulation 42 C.F.R, Part 2, prohibits any further disclosure of this information, except with the specific written consent of the person to whom it pertains. It is understood that the policy of this practice is to release only that information about a client or a former client that is considered essential to the purposes for which authorization is requested.

Print Client Name:_____ Date of Birth:_____

Client's Signature:_____ Date Signed:_____

Witness Signature:_____ Print Witness Name:_____