Authorization for Release of Information

NAME (first, middle initial, last)	*Other names used (if any)*	*Date of Birth*

I authorize Turning Leaf Therapy and the entity listed below to exchange and share information for the purposes of planning, determining, and providing support and services to further the goals set forth in my Individual Treatment Plan.

I am agreeing to release my information To _____ From _____
Name/Title/Agency:_____
Street Address:_____State:_____Zip:_____
Phone:_____ _____ Fax: _____Email:_____

Type of Information to be released:

Program Information	❑
Medical History	❑
Social History	❑
Psychological Information	❑
Progress Notes / Reports	❑
Education Records	❑
Psychiatric Evaluation	❑
Assessment Information	❑
Vocational Evaluations	❑
Therapy / Treatment Information	❑
Medication Administration	❑
Other:	❑
All records pertaining to psychiatric/mental health, chemical dependence and/or HIV/AIDS related information will be released unless otherwise indicated here. DO NOT release records regarding: ❑ Psychiatric Mental Health ❑ Chemical Dependence ❑ HIV/AIDS related information	

- I understand my records are protected under privacy laws and cannot be disclosed without my written consent unless the law allows or requires disclosure.
- I understand what information will be disclosed with this authorization, who will get it, and what it will be used for.
- I understand that if I do not agree to release information described above, it may affect the services I am eligible to receive.
- I understand per the Notice of Privacy Practices that was provided to me that I have a right to restrict the information disclosed.
- I understand that those who receive my records under this release may share it with others.
- I also understand that once the information is shared with others, it is no longer protected by this authorization.

REVOCATION CLAUSE: *I may cancel this consent with written notice at any time, but that this written notice will not affect information the agency has already requested or released. My consent will expire one (1) year from the date I signed if I do not revoke my consent earlier unless a longer period is authorized by law.*

Instructions for signing: Generally, the adult individual (or Legal Representative) or the parent(s) (guardians) of minors should sign the Authorization to Release Information. The Minor's Consent for Medical Treatment Act allows some minors, under certain circumstances, to sign without parents or guardians consent.			
Individual's signature	*Date*	*Legal Representative signature*	*Date*
Signature of Witness	*Date*	*Reason Individual is unable to sign*	
Notice to Providers: The information you provide pursuant to this release may be viewed by the individual unless you specify in writing the statutory basis for withholding the information from the individual.			