Authorization to Use & Disclose Protected Health Information (PHI)

Date: _____

Client Name: _____ **DOB**: _____

Client Address: _____

Purpose for the release of information (ex - legal/continuity of care):

_____

_____

I hereby authorize, Turning Point Inc to release or exchange the following information from my behavioral health record.

Please check all that apply:

☐Intake/Psychosocial Assessment

☐Progress Notes &Treatment Plans

☐Billing Records

☐Verbal and/or Written as requested below

☐Complete copy of file

☐Alcohol/Drug Assessments

☐Alcohol/Drug Treatment Records

☐Diagnosis

☐Verbal only as requested below

☐Other: _____

I authorize release of information to:

_____

Name Phone (if verbal only)

_____

Address

_____

Email (I understand that email is not a secure method of communication)

This form is valid for 1 year unless otherwise specified below:
I understand that I may withdraw my consent at any time.

My authorization is valid from _____ to _____
Date Date

I fully understand that my record contains medical, mental health, substance abuse or other information compiled during my treatment. As such, those records may only be disclosed upon my authorization, as required by law. I understand that records not protected by Federal Rule (42CFR Part 2) may be subject to redisclosure by the recipient of the record.

I understand, Turning Point Inc, in compliance with the Laws of the State of Indiana may have exceptions for release of Protected Health Information which may include: suspected child abuse/neglect, disabled or elder abuse/neglect, court order or danger to self or others.

I further understand that Turning Point Inc will not condition my treatment on whether I sign the authorization to disclose Protected Health Information.

I understand that a copy of this authorization will be placed in my electronic health record file with Turning Point Inc. I understand that I will be offered a copy of this authorization as well.

_____ _____
Signature - Client/Legal Guardian/Legal Representative Date

_____
Printed Name- Client/Legal Guardian/Representative

I, as the service provider for the above client, have discussed the issues above with the client and/or his/her personal representative/guardian. My observations of behavior and response gives me no indication that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of Service Provider Date

This information has been disclosed from records which are confidential. Any further disclosure of it without specific written consent of the person to whom it pertains exceeds the limits of this release. A general authorization for the release of other information is not sufficient for this purpose, even if more restrictive than HIPAA rules. The information released/exchanged is confidential according to state Law 16-39-2.1—2.11 and Federal Title 42 CFR-Part 2. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.