Turning Point Center for
Psychological and Family Growth, LLC
124 East Miracle Strip Pkwy, Suite 302
Mary Esther, FL 32569
Phone: 850-243-8086 FAX: 850-243-2702

AUTHORIZATION FOR RELEASE OF HEALTH RECORDS

1.Regarding Patient ***COMPLETE IN FULL***

Name – Last, First, MI		
Street Address		Telephone Number
City	State	Zip Code
Date of Birth	Social Security Number	

2.Records Released From			**3.Records Released To**		
Name-Last, First, MI			Name- Last, First, MI		
Street Address			Street Address		
City	State	Zip	City	State	Zip
Phone #	FAX #		Phone #	FAX #	

4. INFORMATION TO BE RELEASED :(Check all applicable categories: ONLY ORIGINAL TPC WILL BE RELEASED)

_____ Summary of Records	___ **Progress Notes (Dates: From_____ To:_____)**	___New Patient Intake	___ Initial Visit/Evaluation
____History Forms	___ **Psychological Evaluation (Date: _____)**	___Social History	___Insurance/Billing Records
___Treatment Plan	___Letters From TPC	___Educational Testing	___Alcohol/ Drug Screening Results
___Dates of Attendance	___Discharge Summary/Plan	___Treatment Recommendations	

___Raw Psychological Test Data (To Be Released ONLY to a Psychologist or Qualified Professional)

___Oral Communications (To: _____ _From: _____ To And From: _____)

AUTHORIZATION FOR RECIPROCAL COMMUNICATION BETWEEN PATIENT AND RECIPIENT: *(Please Initial)* **YES _____ NO _____**

5. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

___Further Health Care	___Insurance/Claims	___School Disability	___Academics
___Application for Insurance	___Military Clearance	___Legal (Explain_____)	

Personal (Explain_____)

Other (Explain_____) Restrictions (Explain _____)

6. EXPIRATION DATE OR EVENT: This authorization shall expire no later than: ___/___/_____ or upon the following event _____ whichever is sooner.

7. AUTHORIZATION:

A. I may revoke this authorization at any time by notifying Turning Point Center (Address Listed Above) IN WRITING or by the signature below.

B. I understand that my revocation does not affect any disclosures made prior to the revocation being revealed and processed.

C. I understand that my revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

D. I understand the information disclosed may be subject to unauthorized re-disclosure by the receiving party and may no longer be protected by federal and state privacy regulations.

E. I have the right to inspect or receive a copy, with certain exceptions applying, of the information to be used/disclosed as permitted by federal law. (If requesting inspection of records, speak to your provider. Fees may apply for copies being released for any purpose other than continuity of health care.)

F. I understand that I may refuse to sign this authorization and that signing the authorization is strictly voluntary.

G. If this authorization originated with the provider, I have the right to a copy of this form after I sign it, if I so request.

H. I understand that evaluations performed for Vocational Rehabilitation become the property of the State of Florida, and can be released to the client or others only with the permission of Vocational Rehabilitation.

I. I understand that if I am a Criminal Justice System Referral this consent will remain in effect until there has been a formal termination of the ruling that mandated treatment.

J. I understand that a photocopy of this release shall be as valid as the original.

I have read the above foregoing Authorization for Release of Health Records and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the authorization and that I have the legal authority to sign this document and I authorize the use and disclosure of protected health information.

_____ _____

Signature of Patient (Or Patient's Personal Representative) Date

_____ _____

Printed Name of Patient or Personal Representative Representative's Authority to Sign for Patient, (i.e., parent, guardian, power of attorney, executor)

_____

Address and Telephone Number of the Authorized Representative

_____ _____

Signature of Witness and Title Date

If not signed in the presence of a Turning Point Center Representative, the Patient or Patient Representative Signature must be notarized, or accompanied by a photocopy of your driver's license, at the discretion of Turning Point.

****NOTICE TO PARTY AUTHORIZED TO RECEIVE THIS INFORMATION****

The information requested is from records whose confidentiality is protected by Federal Law. Pursuant to federal Regulations (42 CFR, Part 2 and 42, CRF 164 or HIPAA) further disclosure is prohibited without specific written consent the person to whom it pertains or as otherwise permitted by such regulations. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR 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 client.

(A COPY OF THIS NOTICE MUST BE RETAINED WITH CLIENT'S MEDICAL RECORDS)

I hereby revoke my consent for release of records.

_____ _____

Signature **Date**