TAMMY POWELL LLC
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AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

I, ______________________________________, hereby authorize the ____ Release and/or _____ Exchange
(Name of Responsible Party)

of information relating to the care and/or condition of: ____,
(Name of person in treatment)

D.O.B.: ____________________, from/between _________________________ and the party named below:

____
(Name & Title or relationship to person in treatment)

____
(Address)

____
(Phone Number and Fax)

The purpose of this disclosure is to improve assessment and treatment planning, share information relevant to treatment, and, when appropriate, coordinate treatment services.

Information to be released or exchanged includes information concerning HIV testing or treatment of AIDS, AIDS-related conditions, alcohol or drug abuse, drug-related conditions, and/or mental health conditions.

The information specifically authorized for release/exchange includes:

_____ Diagnostic Assessment
_____ Treatment/Discharge Summary
_____ Social/Family History
_____ Current/Past Medications
_____ Psychological Assessment/Testing
_____ Treatment Recommendations/Plan
_____ Attendance Reports
_____ School Records
_____ Lab Reports
_____ Drug Screens
_____ Physical Exam
_____ Other: ______
____

Information specifically excluded from this authorization includes: ___________________________________
____.

This authorization will remain in effect for 180 days from the date of signature, or will expire on this date, _____________ or event ______________________. This consent may be revoked in writing at any time; however, revocation shall not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my therapist may not condition therapy services upon my signing an authorization unless the therapy services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

A photocopy of this form is considered equivalent to the original.

____ _________________
Signature of Client, Parent, Guardian, or Personal Representative Date

____ __________________
Signature of Therapist, Provider, or Witness Date