

DISCLOSURE AUTHORIZATION

FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date: _____

Release Information To: _____

Address: _____

I hereby authorize Turning Point to release to the above referenced individual(s) or entity (ies) copies of the following medical records.

(Check those categories which apply).

Evaluation

Daily Notes

Discharge Summary

Testing

Progress Notes

All Records

Other (describe): _____

Dates of Service Requested: _____

I would like all photocopies mailed to me.

I would like to arrange to pick up records in the clinic.

This authorization will expire ninety (90) days of signature, or sooner if specifically revoked below (except to the extent that action has been taken in reliance on it.)

Signature of Patient or Authorized Legal Representative
(Describe basis of authority)

Date

Witness Signature

Date

Authorization Revoked

Date