Turning Pointe Counseling & Consulting, LLC
161 S. Liberty Street ~ Powell, OH 43065 ~ (614)-551-9297
Authorization for Release/Exchange of Confidential Information

Client Name _____ (Please Print Clearly) DOB: _____/____/_____

I _____ (Please Print Clearly) hereby authorize Turning Pointe Counseling & Consulting LLC (Kelly Bulinski, LPCC) to furnish and exchange medical, drug and alcohol, psychological, educational information, opinions and records as specifically requested, as well other information requested, as it pertains directly to the counseling/treatment of above identified client. This authorization also authorizes Turning Pointe Counseling & Consulting LLC (Kelly Bulinski, LPCC) to discuss these matters with those individuals or personal of these facilities.

☐ Exchange with ☐ Release to ☐ Obtain from

_____
Name of: Practitioner, Agency, or School

_____ _____
Address Phone number

- **For the Following Period of Time**: From ____/_____/_____ through the present.

- **Type of Information to be Disclosed:**
  - ☐ All records
    - ☐ Medical History
    - ☐ Diagnosis
    - ☐ Assessment Information
    - ☐ Psychiatric/psychological Evaluation
    - ☐ Hospitalization Records
    - ☐ Treatment Plan(s)
    - ☐ Summary of Treatment
    - ☐ Drug / Alcohol Tests and Results
    - ☐ Progress Notes
    - ☐ Attendance
    - ☐ Discharge Summary
    - ☐ Disciplinary Record
    - ☐ Grades
    - ☐ Educational Evaluation
    - ☐ Individual Education Plan
    - ☐ Other _____

- **Purpose of Disclosure of Information:**
  - ☐ Continuity of Mental Health Care and/or Medical Care
  - ☐ Insurance or other third party reimbursement
  - ☐ Other (Specify) _____

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. This authorization may be revoked at any time in writing by the client. Revoking of this authorization shall not cancel any action that transpired prior to receiving the revocation notice. If not revoked, this consent will terminate upon:

☐ 180 days from date of signing release

OR

☐ (date, event, or condition) _____

I acknowledge that I have read this authorization and fully understand the nature of the release I understand that I may revoke it at anytime. I release the director, therapists, employees, and the above named organization from any liability that may arise from this action whether or not foreseen at present.

_____ _____/_____/_____
Client Signature Date

_____ _____/_____/_____
Parent/Legal Guardian Signature Date

_____ _____/_____/_____
Therapist Signature Date