Authorization for the Release or Obtain Confidential Information

Client's Name: _____Date of Birth: _____

I, (fill in name) _____ (relationship to client)

_____ authorize use or disclosure of protected health

information between Donka Turner, MA. LMFT and the following individual/organization:

Name of individual/organization: _____

Email address: _____

Address:_____ Phone: _____

3. The specific information that should be disclosed is (please check boxes for information you request to share):

☐Diagnosis
☐Medical, Educational and/or Psychological/ Psychiatric Assessment
☐Treatment or Client Plan
☐Individualized Family Service Plan (IFSP)
☐Individualized Education Plan (IEP)
☐Individual Program Plan (IPP)
☐Behavioral Treatment Information
☐Other_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

YES, DISCLOSE THIS INFORMATION *_____

NO, DO NOT DISCLOSE THIS INFORMATION * _____

This authorization is valid for one (1) year from the date of signature, unless revoked or a

different date is specified here: _____/_____/_____.

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying Donka Turner, MA, LMFT in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

_____ _____

Parent/Guardian Signature Date