# Authorization for the Release or Obtain Confidential Information

Client's Name: Date of Birth:

I, (fill in name) ____________________________________________ 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: _______________

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: _____/_____/_____. 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. 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