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A Turning Point for Quality Change

Consent to Disclose and Receive Information

I, _____, authorize Turning Point Associates, Inc. to

disclose to and receive from_____, the following

Information:

- ❑ Discharge summary
- ❑ Psychological evaluation
- ❑ Consultation reports
- ❑ Progress notes
- ❑ Education information
- ❑ All information
- ❑ Limitations Discussed in Session
- ❑ Other_____

Exchange of information is to occur by:

- ❑ Telephone
- ❑ Correspondence
- ❑ In person in session

Information exchange is to be:

- ❑ One-way
- ❑ Two-way

I, the undersigned, understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance on the consent form. I further understand that this release expires one year after the signatory date below.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of the information provided without specific written consent from the person to whom the information pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.

_____ _____
Signature of Patient/Client Date

_____ _____
Signature of Parent/Managing Conservator/ Date
Guardian/Legal Representative (if applicable)