The Counseling Professionals
TCP of Ohio, LLC
Release of Information

Client's Name: _____ DOB: _____

I, authorize _____ to:
(Therapist)

_____Disclose Information to: AND/OR   _____Obtain Information from:

Name: _____
Address: _____ City: _____ State:_____ Zip:_____
Phone: _____ Fax: _____

____ Academic testing results	____ Psychological testing results
____ Behavior programs	____ Service plans
____ Progress reports	____ Summary reports
____ Intelligence testing results	____ Vocational testing results
____ Medical reports	____ Entire record, except progress notes
____ Personality profiles	____ other, specify
____ Psychological reports	

The above information will be used for the following purposes:
_____ Planning appropriate treatment or program
_____ Continuing appropriate treatment or program
_____ Determining eligibility for benefits or program
_____ Case review   _____ Updating files
_____ Other (specify)_____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered

by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date:_____

Parent/guardian/personal representative _____ Date:_____
(if applicable)
Witness Signature: _____ Date:_____
NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. However, once the information is released by therapist, it maybe disclosed by the recipient of the information and no longer protected.