Tammy Powell, PCC, LLC
9876 Maineville Rd., Loveland, OH 45140
513-428-4567 (P)

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

I, _____, hereby authorize the ____ Release and/or _____ Exchange
(Name of Responsible Party)
of information relating to the care and/or condition of: _____,
(Name of person in treatment)
D.O.B.: _____, from/between Tammy Powell, PCC, LLC and the party named below:

_____
(Name & Title or relationship to person in treatment)

_____
(Phone and fax numbers)

_____
(Address)

The purpose of this disclosure is to improve assessment and treatment planning, share information relevant to treatment, and, when appropriate, coordinate treatment services.

Information to be released or exchanged includes information concerning HIV testing or treatment of AIDS, AIDS-related conditions, alcohol or drug abuse, drug-related conditions, and/or mental health conditions.

The information specifically authorized for release/exchange includes:

_____ Diagnostic Assessment	_____ Psychological Assessment/Testing	_____ Lab Reports
_____ Treatment/Discharge Summary	_____ Treatment Recommendations/Plan	_____ Drug Screens
_____ Social/Family History	_____ Attendance Reports	_____ Physical Exam
_____ Current/Past Medications	_____ School Records	_____ Other: _____

_____

Information specifically excluded from this authorization includes: _____
_____.

This authorization will remain in effect for 180 days from the date of signature, or will expire on this date, _____ or event _____. This consent may be revoked in writing at any time; however, revocation shall not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my therapist may not condition therapy services upon my signing an authorization unless the therapy services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

A photocopy of this form is considered equivalent to the original.

_____ _____
Signature of Client, Parent, Guardian, or Personal Representative Date

_____ _____
Signature of Therapist, Provider, or Witness Date