

AUTHORIZATION FOR RELEASE & EXCHANGE OF INFORMATION

Client Name:	Date of Birth:		
I hereby give my permission to The TNC Psychotherapy Group, information contained in my medical record. I understand that concerning my psychiatric, psychological, and/or related condias privileged and confidential and cannot be released to me or an expressed and informed consent. In addition, I understand than those designated by me or my personal representative or	t my medical record may contain information itions, and that under law these records are classified those designated by me or my legal guardian without that those records will not be released to entities other		
I authorize the release/exchange of information from/with:			
Name:			
Address:			
Phone:			
The type of information to be disclosed/requested, either verbally or written, is as follows:			
To Be Released * from TNC Psychotherapy Group, PLLC	To Be Requested * from third parties		
Intake Information	Treatment Plans		
Progress Notes	Progress Notes		
Treatment Plans	Health/Medical/Academic Records		
Recommendations	Psychological/Psychiatric Evaluations/Assessments		
Mental Health Information	Court Documents		
Diagnosis/Prognosis	Reccomendations		
Other (Specify):	Other (Specify):		
*Content presented during a private counseling session ("prograthe HIPAA Privacy Rule.	ress notes"), may be protected from disclosure under		
(initial) I understand that The TNC Psychotherapy Group, information necessary to fulfill a request.	PLLC will release only the minimum amount of		
(initial) I understand that I have the right to withdraw my action has already been taken pursuant to the authorization. I do so in writing and present my written revocation to The TNC	understand that if I revoke this authorization, I must		



and The TNC Psychotherapy Group, PLLC wathorization for the requested use or disclosed, as provided in CFR164.524 (with	vill not base my treatment or pelosure. I understand that I ma	·
disclosure by the recipient of the information	ion and is no longer protected	to this authorization may be subject to red by federal confidentiality laws or The TNC ot be held liable for information disclosed to
-	ops out of treatment, is refer	urrent episode of care (treatment has been red elsewhere, moves, or in the case of the ny time.
Release:		
Client Signature/Guardian Signature	Date	
Client Signature/Guardian Signature	Date	
Therapist	Date	
Request:		
Client Signature/Guardian Signature	Date	
Client Signature/Guardian Signature	Date	
 Therapist	Date	