DR. BRENNA TINDALL
& ASSOCIATES

HIPAA COMPLIANT AUTHORIZATION TO RELEASE CLINICAL INFORMATION

(The execution of this form does not authorize the release of information other than that specifically described below.)

Patient Information:	To:	Release to:
		Dr. Brenna Tindall & Associates 918 13th Street, #2 Greely. CO 80631 (primary address) 970-231-9611

As a client of Dr. Brenna Tindall & Associates Forensic Evaluation & Counseling, I realize that information on my case will be discussed with Dr. Brenna Tindall & Associates Forensic Evaluation & Counseling treatment team as a matter of peer review and case coordination. This consent is valid for the period of time necessary to carry out the stated purpose of the request of information. This consent may be revoked at any time in writing. I understand by so revoking, I may have to end my treatment.

I request and authorize the aforementioned doctor, health care provider, facility, etc., to exchange the information specified below to the organization, agency, or individual named on this request. I understand that the information to be released includes the following conditions:

INFORMATION TO BE RELEASED:

( ) Psychosocial History
( ) Discharge Summary
( ) Psychiatric Summary
( ) Education Information
( ) Medication History
( ) Other _____
( ) Psychological Evaluation
( ) Treatment Plan
( ) Summary of Progress Notes
( ) Occupational/Recreational Therapy
( ) Police/Legal Information

I understand that information to be released may include information regarding the following condition(s):

( ) Drug Abuse/History
( ) Alcohol Abuse/History
( ) Sexual History
( ) Psychiatric Conditions
( ) Auto Immune Deficiency (AIDS)
( ) Criminal/Court Records

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

( ) Offense Specific Treatment
( ) Offense Specific Evaluation
( ) Psychological Evaluation
( ) Mental Health Treatment
( ) Psychological Treatment
( ) Forensic Evaluation

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will automatically expire upon satisfaction of the need for disclosure or if revoked in writing by the client (or client's parent or legal guardian). You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

HIPAA REQUIRED STATEMENTS:

- I understand that non-research related treatment may not be conditioned upon signing this release.
- I understand that the information provided under this release may be subject to disclosure by the recipient under circumstances no longer protected by HIPAA Privacy Rules.
- I understand that I may revoke this release at any time, except to the extent that action as already been taken to comply with it. To revoke this authorization, I must provide written notice to the organization or entity to which I have authorized the release of information.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

Person Authorized to sign for client: _____
Print/Type Name

Relationship to client: _____

State how authorized: _____

Ver. 8-2012