AUTHORIZATION OF RELEASE OF CONFIDENTIAL INFORMATION

TRUE NORTH TMS
AT WILLOW MEDICAL

CLIENTS NAME:_____ Date of Birth:_____
Date:_____

Requesting Entity:	Releasing Entity:
True North TMS at Willow Medical 920 East 72nd Ave Anchorage, AK 99518 Phone: 907-344-0753 Fax: 907-222-0754	_____ _____ Street Address _____ City / State / Zip _____ _____ Fax Phone

_____ (initial) I authorize this release to be reciprocal between the two parties.

INFORMATION AUTHORIZED FOR RELEASE

_____ Psychological Evaluations/Reports

_____ Psychiatric Evaluations/Reports

_____ Physical / Medical Records / Med. List

_____ Lab Results

_____ Radiology Reports (CT/MRI)

_____ Emergency Reports

_____ Psychotherapy Notes

_____Social History

_____Vocational/ Work Information

_____ Discharge Summary (ies)

_____Verbal Information

_____ Any documents which may include information regarding **HIV status**.

_____ Any documents which may include information regarding **chemical dependency.**

_____Other _____

I hereby authorize the above information to be released to the party I have indication for the purpose of:
_____continuity of care _____ other:_____
I retain the right to revoke this authorization in writing prior to the expiration date below.

Treatment may not be conditioned on obtaining the authorization if that is prohibited by the HIPPA Privacy Rule. The information disclosed pursuant to this authorization may be subject to re-disclosure by the designated recipient, and subsequently no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Client or Client's Designee *Designee's Relationship to Client*

_____ _____ *TO* _____
Witness *Date Authorized* *Date Authorization ends*