AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

Client Name: _____ Medicaid # _____ DOB: _____

****Circle "By" or "To" for Each Party Listed to Indicate Direction of Information Exchange****

Information To Be Released By / To:	**Information To Be Released By / To** **(specific name if not a treatment entity)**
Therapeutic Life Choices, LLC	
1728 S. Carson Ave.	
Tulsa, OK 74119	
918-406-3420 fax 918-280-0310	

Date Release starts: _____ Date Release ends: _____

Specific Information To Be Released Or Exchanged:

☐ Psychiatric Evaluation	☐ Medical Records	☐ Educational Records
☐ Mental Status	☐ Dates of Hospitalization	☐ Educational Tests
☐ Crisis Intervention Reports	☐ Chemical Recovery Hx	☐ Discipline Reports
☐ Diagnosis	☐ Court/Agency Documents	☐ Psychological Evaluation

☐ Other (specify): _____

Specific Substance abuse info to be released if any (required) _____

_____

Purpose (Required): _____

The information may be shared: ☐ in person ☐ by phone ☐ by fax ☐ by mail ☐ by e-mail

☐ *I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.*

I understand:

- This release of information form will expire one year from the signature date, upon the client's request, or upon the client's discharge of services from this agency;
- Records are kept confidential in compliance with state and federal law, and re-disclosure of the records are prohibited unless specifically authorized by the client;
- I understand that signing this release is voluntary, and a refusal to sign does not affect the client's receipt of services;
- **The signing of this form indicates the client's agreement to release confidential information, including release of information related to communicable diseases such as HIV and AIDS status.**
- I can change or revoke this authorization at any time by written request to TLC.

_____ _____

Client Signature if 14 or older *Date*

_____ _____

Parent/Legal Guardian Signature *Date*

_____ _____

Treatment Advocate Signature *Date*

_____ _____

MHP/Counselors Signature *Date*

File Copy