Katherine Turner, LCSW
Psychotherapist
50 East 91st St, Suite 102
Indianapolis, IN 46240
317-443-9593

Authorization for the Release of Information

Name of Patient/Client_____D.O.B._____
I hereby authorize _____
(Sender: person and facility)
To release any confidential information (specify: _____)
To _____
For the purpose of _____
(reason for request; how information is to be used)
I have read the above statements and voluntarily consent to this disclosure. I understand that my records are protected under the Federal Confidentiality Regulations and under the General Laws of Indiana, and cannot be disclosed without my written consent except as otherwise specifically provided by the law. I release my therapist, analyst or other employees from any liability arising from the release of this information to the designated recipient, provided the said release of information is done substantially in accordance with applicable law.

Any information received that is authorized by my consent shall not be further transferred without an additional written consent from me. (Federal regulations 42 CFR Part 2.)
I may withdraw this consent by giving written notification to the above party (sender) at any time prior to the disclosure or release of the information. In the absence of my prior withdrawal, this consent will expire ____ days after it is signed.

_____ _____ _____
Signature of Patient/Client Date on which consent was signed

_____
Signature of Witness