AUTHORIZATION OF RELEASE OF CONFIDENTIAL INFORMATION

TRUE NORTH TMS
AT WILLOW MEDICAL

CLIENTS NAME:_____ Date of Birth:_____

Requesting Entity: True North TMS at Willow Medical	Releasing Entity:_____
920 E 72nd Avenue Street Address	_____ Street Address
Anchorage, Alaska 99518 City / State / Zip	_____ City / State / Zip
(907) 222-0754 / (907) 344-0753 Fax Phone	_____/_____ 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*