Tompkins Alternative Counseling
Removing the Barriers Between You and Counseling

I, ______________________________, whose Date of Birth is _______________, authorize Tompkins Alternative Counseling to **disclose to and/or obtain from**:

____ the following information:
[Insert Name of Person or Title of Person or Organization]

(Patient/Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment

______Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
______Psychotherapy Notes*
______Whole Record
______Other_______________________

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Adam Scholl at 318 N. Aurora St., Ithaca NY 14850.

Unless sooner revoked, this authorization expires on the following date: ________________ or as

otherwise indicated:____

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.
If requested, I will be given a copy of this authorization for my records.

____ ____________________
Signature of Patient Date

____ ____________________
Signature of Parent, Guardian or Personal Representative Date

____ ____________________
Signature of Staff Witness Date