Temple University
Tuttleman Counseling Services
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Philadelphia, PA 19121
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Consent to Release Confidential Therapeutic Treatment Information

I, _____, (TUID) _____ (DOB) _____ do hereby authorize Tuttleman Counseling Services consent to release [ ] and / or receive [ ] the following verbal and written information:

[ ] Psychiatric Diagnosis
[ ] Drug and Alcohol Information
[ ] Medical Diagnosis
[ ] HIV/AIDS Diagnosis
[ ] Treatment Summary / Letter
[ ] Verification of contact with TCS only
[ ] Psychological Testing / Assessment Results
[ ] Treatment Progress / Prognosis
[ ] Level of Care Recommendation
[ ] Medication
[ ] Copy of Chart
[ ] Other

***to* [ ] and/or *from* [ ]**

Name: _____
Address: _____
_____
Phone: _____ Fax: _____

for the purposes of:

[ ] Verification of Contact with TCS Only
[ ] Coordination of Care
[ ] Psychoeducation Services
[ ] Emergency Contact
[ ] Attendance/Adherence to Care
[ ] Other _____

The information will be released in the following form(s):

[ ] Written
[ ] Videotape
[ ] E-mail
[ ] Verbal / Phone
[ ] Audiotape
[ ] Fax

The nature of this release has been explained to me and I understand the following (initial each section):

_____ I have the right to refuse to sign this form and may rescind this consent at any time to the degree that action has already been taken.
_____ I understand my records may contain information regarding HIV/AIDS diagnosis, medical diagnoses, drug and alcohol diagnoses, psychiatric diagnoses, and prescribed medication including but not limited to notes, records, and transcripts of civil commitment proceedings under the Pennsylvania Mental Health Procedures Act, 50 P.S. 7301 et seq.
_____ I understand my records may contain information about my sexual orientation, gender identity, and gender expression.
_____ I understand that any disclosure of information is governed by all applicable federal and state regulations governing the Confidentiality of Patient Records.
_____ I understand that the use of electronic communication (fax and e-mail) does not guarantee the confidentiality of information being disseminated.
_____ I have been informed that I have the right under Pennsylvania law to inspect any of the materials being released.

I am authorizing the disclosure of this information to the parties heretofore mentioned. The above-named healthcare providers may not condition treatment or payment on whether the above-listed patient executes this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

This consent will automatically expire ***one year*** [ ] from the date of my signature (specify date) _____ or ***on the following earlier date or event*** [ ] _____ and cannot be renewed without my written consent.

I have received [ ] refused [ ] a copy of this form for my records.

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Witness Signature	Printed Name	Date

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