TURNING POINT RECOVERY CENTERS

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, ____, hereby authorize
Turning Point Recovery Centers, 54 Seneca Street, Pontiac, MI 48342
to release information contained in patient records to the person or organization listed below.
Information may include any of the following:

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

1. Name, title, address, and organization to whom the disclosure is to be made:
   Name ____
   Organization RECORDS DEPOSITION SERVICE P. 248-357-3330
   Address P.O. BOX 5054, SOUTHFIELD, MI 48086-5054 F. 248-357-3337

2. Specific type, extent or nature of information to be disclosed: (The patient's initials next to each checked box)
   ☐___Assessment ☐___Discharge Summary ☐___Identifying Info.
   ☐___Pysch. Evaluation ☐___Physical Exam ☐___Progress Report
   ☐___Emergency contact ☐___Aftercare plan ☐___Telephone Consult
   X ☒___Other SEE ATTACHED SUBPOENA

3. The purpose or need for such disclosure: (Therapist checks appropriate boxes)
   ☐Referral for services ☐Assessment of patient ☐___Emergency contact
   ☐Coordination of care ☐Care planning
   ☒Other PRE-TRIAL DISCOVERY

4. Revocation of Authorization: This authorization may be revoked by me at any time by my written notice to the above named individual or organization, except to the extent that the person or the organization which is to make the disclosure has already taken action in reliance on it.

5. If not previously revoked by me in writting, this Authorization is effective on this date and will expire one year following discharge from treatment or ________________
   (date/condition/event)

6. I understand that generally Turning Point may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Patient Signature ______________________________ Date ____________________

Birth Date ____________________ Social Security # ____________________

Witnessed By ______________________________ Date ____________________