Turning Point, Inc.
Consent for the Release of Information

I hereby authorize Turning Point, Inc. and RECORDS DEPOSITION SERVICE, INC.
(Other agency or person)
PO BOX 5054
SOUTHFIELD, MI 48086-5054
P: 248.357.3330
F: 248.357.3337

to release/exchange information regarding _____.
(Client's Name)

The information to be released/exchanged will be confined to the following:

_____.

The purpose of the disclosure is only to coordinate services delivered to the client by the

above named organization.

This information will be given Verbally_____
In writing_____
Hand Delivered_____

This consent may be revoked at any time. If not revoked, this consent expires in four months from date the consent is signed, or on the following specified date:
_____.

_____ _____
Client Date

_____ _____
Parent/Guardian Date

_____ _____
Witness Date

NOTE OF RECIPIENT OF INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Unless the records of your program are also subject to the federal Law, Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

SC/1/06