Transfer Plan Clinician Incapacitation or Termination of Practice Form

Clinician:
Name
Practice Name
Address
City, State, Zip
Phone
Fax
Web site
email
Location of records if different from practice address

Custodian

Name
Practice Name
Address
City, State, Zip
Phone
Fax
Web site
email

I, (your name) in the event of my death, disability, retirement or inability to provide counseling services appoint (custodian's name) as custodian to provide these services and will possess and maintain my clinical records for the period 0f _____years. (Custodian's name) is named in my informed consent document. Moreover, I have provided my custodian, location (s), keys, passwords, access codes, and all means to execute this transfer plan.

The duties of my custodian shall include, but not limited to:

- Notification of all active clients or my inability to practice and offer counseling or referral services
- Notification of all active clients that the custodian has possession of the client's clinical records.
- Respond to requests for information in concert with state laws, HIPAA guidelines, and codes of ethics.
- Possess and maintain all clinical records for a period of _____years.
- After _____years destroy/shred

Signed: _____Signed: _____
Clinician Custodian

State of _____
Parish of _____
Dated: _____ _____
Notary Public

Dated: _____ _____
Witness

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