TRANSFER PLAN
CLINICIAN INCAPACITATION OR TERMINATION OF PRACTICE FORM

Clinician

Name _____

Practice Name _____

Address _____

City, State, Zip _____

Phone _____

Fax _____

Website _____

E-mail _____

Location of records if different from practice address_____

_____

Custodian

Name_____

Practice Name_____

Address_____

City, State, Zip _____

Phone _____

Fax _____

Website _____

E-mail _____

I, _____ in the event of my death, disability, retirement or inability to provide counseling services appoint _____ as custodian to provide those services and will possess and maintain my clinical records for a period of _____ years. _____ is named in my informed consent document. Moreover, I have provided my custodian, location(s), keys, passwords, access codes, any and all means to execute this transfer plan.

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

- Notification of all active clients of 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 code of ethics.
- Possess and maintain all clinical records for a period of _____ years.
- After _____ years destroy/shred all records.

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Signed: _____ Signed: _____

Clinician Custodian

State of _____ County _____

Dated: _____ _____

Notary Public

Dated: _____ _____

Witness