New Life Counseling
130 West Third Street Dover, OH 44622
330-343-6600(phone) 330-343-6405 (fax)

☐ ***REQUEST RECORDS***
☐ ***Request Now*** ☐ ***Future Use***

☐ ***RELEASE RECORDS***
☐ ***Release Now*** ☐ ***Future Use***

REQUEST/AUTHORIZATION to RELEASE PROTECTED HEALTH INFORMATION

CLIENT NAME _____

DATE OF BIRTH _____ ***SSN:*** _____

By signing this form, I understand that confidential psychological and psychiatric information can be released to, requested from or discussed with the people or agencies listed below as noted by the exclusions or limitations I have marked below. This form is signed voluntarily and I understand that I can make changes at any time.

1. ***Name:*** _____

   Address: _____

   City: _____ ***State:*** _____ ***Zip*** _____

   Phone: _____ ***Fax number:*** _____

2. ***DESCRIPTION OF MENTAL HEALTH INFORMATION TO BE DISCLOSED:***

☐ ***Intake & Discharge Summaries***	☐ ***Progress Notes***	☐ ***Psychological Testing***	☐ ***Medications***
☐ ***Observations & Recommendations***	☐ ***Medical Evaluations***	☐ ***Psychological Reports***	☐ ***Clinical Impressions***
☐ ***Treatment Plan Compliance***	☐ ***Treatment Summary***	☐ ***Alcohol & Substance Abuse***	☐ ***Attendance Verification***
☐ ***Developmental/Social History***	☐ ***Other*** _____		

☐ ***ALL OF THE ABOVE***

3. ***PURPOSE OF DISCLOSURE***

☐ ***Consultation (verbal or written)***	☐ ***Continuation of Care***	☐ ***Ongoing Treatment Services***
☐ ***Psychological Evaluation Report/Feedback***	☐ ***Forensic Purposes***	☐ ***Treatment Planning***

- ***I have had explained to me and fully understand this request for/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that this release is good for a period of 365 days from the date it was signed.***

- ***I understand that if the person or entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be re-disclosed by the recipient and no longer protected by these regulations. This does not apply to drug and/or alcohol abuse information that may be disclosed. Drug and/or alcohol abuse information and records are protected by Federal Confidentiality Rule 42 CFR Part 2. The federal rules prohibit from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.***

- ***I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my health care treatment or the payment of my health care treatment. I understand that I may revoke this authorization in writing by notifying New Life Counseling, except to the extent that action has been taken in reliance on this authorization.***

_____ _____
Client Signature / Signature of Parent or Legal Guardian ***Date***

☐ **Client given copy**
☐ **Client declined copy**

_____ _____
Witnessed by - Staff Member Signature ***Date***