

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

**Authorization to Release Confidential Information to Family Members**

**CLIENT NAME** \_\_\_\_\_

**DOB** \_\_\_\_\_

I understand that the purpose of this release is to assist with my or my minor child's treatment by improving communication between New Life Counseling, the designated counselor, and the important individual(s) in my or my minor child's life. To further this goal, I authorize New Life Counseling to release the below-specified information regarding me or my minor child to the individual(s) listed below, and to receive information from them. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

The information to be disclosed is marked by an X in the boxes below:

Name of therapist	Name(s) of treatment program(s)	Admission/discharge information
Treatment plan	Progress notes	Compliance with treatment
Treatment summary	Discharge plans	Psychological evaluation
Medications		

Other:

***ALL OF THE ABOVE***

This information is to be disclosed to these persons, who have the indicated relationship to me or my minor child:

\_\_\_\_\_  
Name of person

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name of person

\_\_\_\_\_  
Relationship

This release will expire one year from this date or upon my or my child's discharge from treatment by this agency. I understand that I may revoke this release at any time or by the person specified above. 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.

***This form is signed voluntarily and I understand that I can make changes at any time.***

\_\_\_\_\_  
Signature of client/parent/guardian/representative

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witnessed by - Staff Member Signature

\_\_\_\_\_  
Date

**Scheduling Authorization**

I give consent for the following person(s) to schedule, change, or cancel appointments on my or my minor child's behalf.

\_\_\_\_\_  
Name of person

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name of person

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Signature of client/parent/guardian/representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witnessed by - Staff Member Signature

\_\_\_\_\_  
Date