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
- ❑ Treatment plan
- ❑ Treatment summary
- ❑ Medications
- ❑ Other: _____
- ❑ Name(s) of treatment program(s)
- ❑ Progress notes
- ❑ Discharge plans
- ❑ Admission/discharge information
- ❑ Compliance with treatment
- ❑ Psychological evaluation
- ❑ ***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 to speak to Relationship Phone Number

_____ _____ _____
Name of person to speak to Relationship Phone Number

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 who can schedule for you Relationship

_____ _____
Name of person who can schedule for you Relationship

_____ _____
Signature of client/parent/guardian/representative Date

_____ _____
Witnessed by - Staff Member Signature Date