NEW HORIZONS COUNSELING, LLC

4578 William Penn Highway, Murrysville, PA 15668 (724) 972-6409

Joan McCullough-Crissman, MA, LPC

RELEASE OF INFORMATION

Patient's Name	Birth Date	Last 4 Digits - Member's SSN
_____	_____	_____

Street Address	City	State	Zip Code
_____	_____	_____	_____

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information)Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for confidentiality of alcohol and Drug Abuse Patient Records) Title 42 of the code of Federal Regulations Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.
I understand that my records may contain information regarding my mental health, substance use or dependence, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.
I also understand that my health plan may not condition treatment, payment enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in it health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying, New Horizons Counseling, LLC in writing, but if I do, it will not have any effect on any actions NHC, LLC took before it received the revocation.

I hereby authorize New Horizons Counseling, LLC to (check all that apply):

☐ Exchange with ☐ Release to ☐ Obtain from **the parties I have indicated below**

I hereby authorize New Horizons Counseling, LLC to exchange / release / obtain information:

☐ Verbally only ☐ in written form only ☐ both verbally and in writing

Person/organization receiving/communicating the information:

Name: _____

Address: _____

City: _____ State_____ Zip_____

Phone Number: (____) _____--_____ Extension _____

Description of Individually identifiable health information (check appropriate type(s) of information) to be released/exchanged/obtained:

☐ All ☐ Treatment Plan(s)
☐ Clinical records ☐ Outpatient Progress Reports
☐ Attendance Only
☐ All pertinent documentation New Horizons Counseling, LLC deems appropriate for the purpose(s) checked below
☐ Other (describe): _____

The Purpose of this release is (check all that apply):
☐ To allow the clinically appropriate management and coordination of the Patients mental health and/or substance abuse treatment
☐ Other (describe): _____

The dates of records to be disclosed:
From _____ (MM/DD/YYYY) To _____ (MM/DD/YYYY)

THE PATIENTS OR PATIENT'S REPRESENTATIVE, MUST READ AND SIGN OR INITIAL THE FOLLOWING STATEMENTS:

I understand that this authorization will expire:
☐ On _____ (MM/D/YYYY) or one year from the date of signature below
OR
☐ Once the following event occurs: _____

(***Form must be completed before signing***)

_____ _____ _____
Signature of Patient/Legal Guardian Signature of Minor Patient Date

_____ _____
Print Name of Patient/Guardian Relationship to the Patient

_____ _____
Witness Signature Date of Witness Signature

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION