New Start Recovery
Addiction Wellness Clinic

{Patient Information Sticker}

Patient's Name _____ Date of Birth _____

Address _____ Phone # _____

I, _____, hereby authorize
FULL NAME OF PATIENT

New Start Recovery, Inc to release information specified below from my
NAME OF FACILITY

behaviroal health records covering the dates of service _____ to _____

The information which is checked (X) below is to be released to:

_____
NAME OF HOSPITAL, PHYSICIAN, SERVICE AGENCY OR THIRD PARTY (Provide fax # if hospital or physician)

_____
ADDRESS CITY STATE ZIP

Purpose for Release: ☐ Medical ☐ Insurance ☐ Legal ☐ Other _____

Purpose of Release is not required for patient/personal representative requests.

Check off items being released:

- ☐ Discharge Summary
- ☐ Aftercare Plan
- ☐ UDS and/or Alcohol Breath Test
- ☐ Evlaution & Assessment Reports
- ☐ Porgress Notes
- ☐ Treatment Plan
- ☐ Financial
- ☐ Medical/Physical Information
- ☐ Insurance Information
- ☐ Releases & Aggrements
- ☐ Correspondance
- ☐ Entire Record
- ☐ Treatment Progress Reports
- ☐ DIscharge Letters
- ☐ Emergancy or Family Contact

Other _____

Method of Delivery: ☐ Paper ☐ Fax # _____ ☐ Email _____

The patient's express authorization is required to release certain types of records, including Electronic Medical Records, alcohol and/or drug abuse treatment and information, HIV testing and treatment, psychiatric treatment, and genetic testing (defined in the Genetic Information Non-Discrimination Act of 2008 - GINA, section 201 7 A and B). To authorize release of this information, please read and sign the following:

I, _____, authorize the release of **alcohol and/or drug abuse** treatment and information.
(Patient's Signature)

In authorizing the release of the confidential information identified above, I hereby waive all restrictions or privileges imposed by law and release New Start Recovery, Inc. and their staff from any restriction or privilege imposed by law in connection with the disclosure or release of any professional record, observation or communication. I do understand that the information that is being released may be subject to re-disclosure by the recipient and may no longer be protected. I understand that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

This authorization may be revoked in writing at any time, except to the extent that New Start Recovery, Inc. has already taken action in reliance on it. Letters to revoke this authorization should be addressed to Clinical Staff, 600 W Tunnel Blvd, Houma, LA 70360.

If not previously revoked in writing, this authorization will terminate upon release of the requested information or expire in six months.

_____ _____ _____
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE | RELATIONSHIP TO PATIENT | DATE SIGNED

_____ _____
ADDRESS | PHONE NUMBER

_____ _____ _____
SIGNATURE OF WITNESS (if patient is unable to sign) | RELATIONSHIP TO PATIENT OR CREDENTIALS | DATE SIGNED