NEW VISION COUNSELING

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Authorization for Use/Disclosure of Health Care Information

Client name: _____ Date of Birth: _____
Previous or Other Name (if applicable):_____

I request and authorize New Vision Counseling to release/obtain the health care information described below to/from:

Name or organization (if applicable):_____
Address: _____
City, State: _____ Zip Code: _____
Phone: _____ Fax: _____

This authorization applies to the following information:

☐ Assessment ☐ Treatment Plans ☐ Progress Reports
☐ Other_____

During the following period: _____

The purpose of the disclosure is as follows:

☐ At the request of the above client or authorized representative.
☐ Other_____
This authorization will expire on: _____

☐ I understand that I have the right to revoke this authorization by making a written request to my therapist or the privacy officer.

☐ I understand that New Vision Counseling may not condition my treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization, unless the services I am receiving are solely for the purpose of creating health information for disclosure to a third party (e.g., an independent evaluation).

☐ I understand the potential for the information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient.

☐ I understand that my express consent is required to release any health care information related to psychiatric disorder/mental health or drug/alcohol treatment or use.

Signature (client or authorized representative) _____ Date: _____
Relationship (if authorized representative) _____