# Patient Name: Date of Birth: Phone #:

(Please print)

## 

**I authorize release**

(Please Circle One) **To / From:**

New Terrain Therapy, LLC

11178 Huron Street Suite 201

Northglenn Co 80234

Ph: 720-910-2816

Fax: 303-955-8109

(Please Circle One) **To / From:**

\_

Name of Person or Entity

\_

Address

City and State

Phone # Fax #

### My *initials* below signify that I consent for the following type(s) of information to be released to the above individual/entity.

Substance Use Disorder Information Psychiatric conditions \_ HIV or AIDs related information \_Medical conditions

Do **not** release the following:

### Treatment Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information that may be released:**

**Discharge Summary Physician’s Psychiatric Evaluation Physician’s Progress Notes History and Physical Exam Report Lab Results Medication Record Discharge Plan/Continuing Care Plan Psychosocial Assessment Intake Assessment Substance Abuse/Use Documentation Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Entire Record**

**Verbal Exchange**

**PURPOSE FOR WHICH INFORMATION IS TO BE USED:**

Continuing School Disability Determination/Benefits Payment/Billing

Care/Treatment/Care Personal Employment conditions Coordination

Legal Other

Healthcare Operations

If for legal purposes, give specific reason: (must be completed)

### AUTHORIZATION:

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure. Refer to the Notice for Privacy Practices regarding authorized disclosures. A legible copy of the Authorization or my signature thereon may be used with the same effectiveness as an original. Any information protected by Federal Regulations governing confidentiality of substance use disorder patient records (42 CFR Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure. Business is not liable for such re-disclosures.

This consent expires one (1) year from the date below unless otherwise specified:

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature of Patient (15 years and older)** | **Date** | **Signature of Parent/Guardian, if applicable** | **Date** |
| **Witness, if applicable** | **Date** |  |  |

***Revocation: I hereby revoke the above authorization: Signature Date***