New Directions Counseling
Authorization Form

This form, when completed and signed by you, authorizes the release of protected information from New Directions counseling records to the person(s) you designate. I authorize Rebecca Waterston, M.A., LMHCA to release:

- ❒ Only that I am a client of New Directions Counseling and no other details
- ❒ Type of Treatment I am receiving (e.g.: CBT – Cognitive Behavioral Therapy, L.I. – Lifespan Integration Therapy) but not to include any details about confidential information shared in session.
- ❒ Therapeutic diagnosis as currently (or unofficially) assessed, but no confidential details
- ❒ Nature of the counseling and specific confidential things shared by client as stated below:

Including:	Excluding:
_____	_____
_____	_____
_____	_____
_____	_____

I am requesting the release of this information for the following purposes *("at the request of the individual" is all that is required if you do not wish to state a specific purpose)*:

_____

This information should only be released to *(name and address of the person(s) to whom the information is to be released)*: _____ Expiration Date: _____

I understand and agree that a copy of this authorization (e.g. electronic copy, fax, or photocopy) shall have the same force as the original.

I understand that I have the right to revoke this authorization at any time by giving spoken or written notification to the Counseling Service. However, my revocation will not be effective if the Counseling Service has already shared the information specified in the authorization with the designated recipient.

I understand that my counselor generally may not condition psychological services upon my signing this authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that I have the right to inspect the disclosed mental health information at any time.

I understand that state and federal laws concerning mental health treatment information prohibit re-disclosure by the recipient of the information specified in this authorization, **when the recipient is covered by federal or state privacy regulations.** The Luther College Health Service and off-campus mental health treatment providers and medical providers are covered by federal or state privacy regulations that pertain to mental health information and so are prohibited from re-disclosing the information my counselor shares with them.

I also understand that if the recipient is not covered by federal or state privacy regulations, the recipient may choose to share this information with others and the Luther Counseling Service has no control over this re-disclosure. Luther College offices that are not governed by federal or state privacy regulations pertaining to mental health information include all campus offices and employees except the Health Service and Counseling Service.

Signature of Client _____ **Date:** _____

Printed Client Name: _____