NEW LEAF
COUNSELING OF THE RIVER VALLEY

AUTHORIZATION AND REQUEST FOR RELEASE OF INFORMATION

Client Name: _____ **Date of Birth:** _____

Address: _____

RELEASE OF INFORMATION:

I, the undersigned, authorizes and requests that New Leaf Counseling of The River Valley, Inc. to obtain from and/or furnish health information from the medical records of the above-named person for the following purpose: clarify diagnosis, formulate treatment plan, continuum of care, and aftercare.

Release Information to: (select one)

☒ _____ _____
Name of person and/or organization Relationship to client

☐ New Leaf Counseling of the River Valley, Inc.

FOR THE PURPOSE OF:

☐ My own personal medical record keeping ☐ Provide progress report/letter to Probation Officer

☐ Review by a lawyer/attorney ☐ Response to Legal system/court/subpoena

☒ Treatment from PCP physician, specialist, or another provider. ☒ Treatment and continuum of care

☐ Receive treatment from another treatment facility (clinic; hospital; residential facility)

☐ Other Purposes Not Listed above: _____
and for that purpose only.

I further authorize and request that you provide such copies thereof as may be requested with no limitation placed on dates, history of illness, and/or diagnostic information**.**

THE INFORMATION TO BE RELEASED IS CONFINED TO THE FOLLOWING:

☒ Verbal Communication ☒ Diagnosis ☐ Ability to sit in on sessions with therapist and client ☒ Record of attendance

☒ Letter of Report of progress and/or recommendations by therapist ☒ Scheduled appointments ☒ Discharge Summary

☒ Profile demographic information ☐ Psychological Testing Report ☐ Progress Notes (Individual; Family)

☒ MHP Diagnostic Evaluation or Summary of Diagnostic Evaluation as deemed appropriate by MHP

☐ Other information to be released not listed above: (please be specific): _____

_____

FORMAT OF RELEASE: ☒ Written ☒ Verbal ☒ Electronic through Secure or Encrypted Messaging

TIME PERIOD OF TREATMENT COVERED FOR RELEASE: (select one)

☒ Current/Last Episode Start Date through Termination of this

☐ Release One Year ago through Termination of this Release

☐ All previous Episodes Start Dates through Termination of this Release

This authorization expires: (select one)

☒ **one year** from the date signed or

☐ **90 days from the date signed.**

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein described. I understand that this authorization may be withdrawn by me at any time except to the extent that action has been take in reliance upon it. I acknowledge that the material authorized for release may contain, alcohol, substance use or dependence, sexuality, psychiatric, and/or psychological information, and also may contain confidential HIV/Aids and/or communicable or non-communicable disease related information. I understand that disclosure of health information to a party other than the one designated above is forbidden without additional authorization on my part. I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient unless the health information is protected under federal confidentiality rules 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996, 45 CFR its. 160 and 164. This facility is released and discharged from any liability and the undersigned will hold the facility harmless for complying with this "Authorization and Request for Release of Information".

I understand that I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance thereon. I have the right to inspect or copy the information to be disclosed and/or any authorizations I have signed. A fee may be charged for copying/releasing medical records. I also understand that the receiving agency/person may not protect the confidentiality of the information.

SIGNATURES:

_____ _____

Patient Signature Witness Signature

_____ _____

Parent or Legal Guardian Date

PROHIBITION OF REDISCLOSURE: *This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation 42 C.F.R., Part 2 prohibits you from making any further disclosure of it without the specific written consent of the person to who it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.*