New Outlook Counseling Center

AUTHORIZATION TO RELEASE AND OBTAIN INFORMATION

I, (Name) _____(Birthdate) _____

(SS #), _____, (Address)_____

hereby authorize my therapist and/or office personnel at New Outlook Counseling Center, Inc at the Bloomington and/or Greenwood, Indiana facility, to release information contained in my client record in either verbal, written, and/or electronic format to:

_____
(Name)

_____
(Address)

_____

_____
(Phone)

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and applicable State statutes. The Federal rules prohibit you from making any further disclosure of this information unless further discloser is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part E. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Initial those areas that can be released and/or obtained

The purpose and need for such disclosure is:

Initial Assessment _____
Diagnosis _____
Staffing Reports _____
Appointments (missed/attended) _____

Treatment Recommendations _____
Discharge Summary _____
Progress Notes _____
Court Related Reports _____
Other _____

The purpose and need for such disclosure is:

_____Coordination of services and continuing care
_____Referral to another provider for treatment
_____Other:_____

_____Determine need for and/or type of service
_____Attorney/Court Request

This release expires upon the following conditions:

*One (1) year from the date of my signature
*When it is no longer needed for the purpose for which it was given.
*Termination of Services.
* Other date, event, or condition.

I understand that my records are protected by State and Federal Confidentiality Rules and cannot be disclosed without my written authorization unless release is required by other regulations. I understand that this authorization may be revoked at any time by written notification to New Outlook Counseling Center, Inc., unless the information has already been released. My signature authorizes that a copy of the document is a valid as the original.

_____ _____

(Client Signature) (Date) (Parent/Guardian Signature) (Date)

I verify the identity of the person and believe that they have knowledge of what he/she is consenting to and is able to give consent.

(Witness Signature) (Date)