

**Consent for Release of Private Information**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I hereby authorize New Beginnings Emotional Wellness & Holistic Therapies to

\_\_\_\_ obtain information from \_\_\_\_give, mail, fax information to \_\_\_\_talk with

Agency/Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be released**:

\_\_\_\_Current medication list \_\_\_\_Current diagnoses and problem list

\_\_\_\_Office visit/ progress notes \_\_\_\_Discharge summary/note

\_\_\_\_History and Physical Exam \_\_\_\_Diagnostic Assessment Report

\_\_\_\_Psychological Testing Results/Report \_\_\_\_Treatment Plan

\_\_\_\_Chemical Health/Substance Abuse Records

\_\_\_\_Other

**Purpose of the Release:**

\_\_\_\_Coordination of Care and Services \_\_\_\_Personal Use or Review\*

\_\_\_\_Insurance Eligibility, Payment or Claim \_\_\_\_Transfer of Care/Referral

\_\_\_\_Legal / Litigation\* \_\_\_\_Other

\*may be a charge related to records released from NB Holistic Therapies

* This authorization will remain in place for one year from the signature date unless an alternate expiration date is entered here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* This authorization may be cancelled in writing at any time. A cancellation will not change any releases which happened before the cancellation is received.
* Private / protected information will not be given to others unless written consent is given or the law specifically allows for its release.
* Treatment will not be restricted if you choose not to sign this authorization; however, choosing not to sign could interfere with, or prevent you from, achieving your treatment goals.
* A photocopy of this authorization will be treated in the same way as an original.
* Your signature indicates that you have been informed why you have been asked to consent to the release of the above information and how the information will be used.
* New Beginnings Emotional Wellness & Holistic Therapies cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release New Beginnings Emotional Wellness & Holistic Therapies from all liability resulting from a re-disclosure by the recipient.

I understand I am not required by law to consent to the release of this information. By signing this form, I acknowledge that I have read, or had explained to me, and understand this form and authorize release of the information described above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

If client is unable to sign this authorization, please complete the following information

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substitute Decision-Maker’s Name Relationship to Client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substitute Decision-Maker’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Staff / Witness Date