A New Beginning Counseling Center

Authorization for Release of Information

Patient Information

Patient Name_____ Date of Birth:_____

Phone:_____

Mailing Address_____

Requestor Information

(To be completed if authorization is being made by someone other than the subject of the information. Please provide proof of your authority.)

Requestor Name: _____ Phone: _____

Mailing Address: _____

Authorization Details

I authorize the following individual, organization or business:_____

to disclose my confidential information to: _____ for the

purpose of:_____.

Please describe in detail the information to be disclosed:

_____

_____

_____.

This authorization will expire in 6 months unless another date is specified here:

_____.

I understand that, at my request, a copy of the completed and signed authorization form will be made available to me. I understand that I make revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization.I may submit my written statement of revocation to A New Beginning Counseling Center. I understand that the person or entity who receives my confidential information may not be required to prevent unauthorized use or disclosure.

I understand that authorization, unless expressly limited by me in writing will extend to all aspects of my treatment including testing and/or treatment for sexually transmitted diseases, AIDS, HIV infection, alcohol and/or drug abuse and mental health conditions.

I understand that my signature on this form is not required for treatment, payment, enrollment or eligibility for benefits and that a copy of this authorization shall be as valid as the original.

Signature: _____ Date: _____