AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

I, _____ **DOB:_____**

(Patient Name)

hereby give my permission to **New Outlook Counseling Center**, to release or request from a third party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in federal law.

This information will be released/requested upon request to the following:

To/From:_____

Organization/ Office/ Individual's Name, First and last name, phone, FAX and address of person(s.) Please call the office and get their direct fax line.

Initial the type of information to be disclosed/requested is as follows:

To Be Released * *from **New Outlook Counseling Center***

_____Treatment Plans/Recommendations

_____Process Notes

_____Appointments (missed/attended)

_____Reports(s) of Progress

_____Initial Assessment and Diagnosis

_____ Verbal Communication

_____Other (Specify): _____

To Be Requested * *from third parties*

_____Treatment Plans/Recommendations

_____Process Notes

_____Health/Medical/Academic Records

_____Psychological/Psychiatric Evaluations/Assessments

_____Court Documents

_____Verbal Communication

_____Other (Specify): _____

** Records requested are for Continuity of Care**

** In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("process notes"), such records may be protected from disclosure under the HIPAA Privacy Rule).*

_____ (initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to **New Outlook Counseling Center** or assign a date here:_____

_____**(initial)** I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and **New Outlook Counseling Center** will not base my treatment or payment whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

_____**(initial)** I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or **New Outlook Counseling Center**. **New Outlook Counseling Center** will not be held liable for information disclosed to another party per the client's request.

_____**(initial)** I understand that **New Outlook Counseling Center** will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death.) This agreement is subject to revocation in writing at any time.

Release:

_____

Signature Client/Next of Kin/Guardian **Date**

_____

Clinician Signature/Credentials **Date**

Request:

_____

Signature Client/Next of Kin/Guardian **Date**

_____

Clinician Signature/Credentials **Date**

NEW OUTLOOK COUNSELING CENTER

5010 N Stone Mill Road
Suite B
Bloomington, IN 47408

Return FAX: (888) 789-8394
for both office locations.

501 S. Madison Street.
Suite 105
Bloomington, In 47403

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS INSTRUCTIONS

Instructions:

- To/From Field: Enter the office the records will be requested or released to, can add the provider's name as well. Please include email or fax. You can get this by calling their office. Many Offices/Providers share the same name. (Hint: This is NOT New Outlook)

- Release Column- This column is for New Outlook to receive information. (Do not use X's or check marks this form requires initials ONLY)

- Requested Column- This column is for New Outlook to give information)

- (Both Columns are needed for back-and-forth communication
- Signature- Both Signature spaces need signed.