NEW LEAF COUNSELING

929 S Washington St Junction City, Kansas 66441
785.802.9024
Tessa.Gutierrez@newleafcares.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: Date of Birth:

- ***I AUTHORIZE NEW LEAF COUNSELING TO RELEASE THE FOLLOWING INFORMATION*:**

□ Evaluation □ Progress Notes □ Verbal communication □ Admission Summary
□ Complete Chart □ Discharge Summary □ Treatment Summary □ Other:_____

- ***THIS INFORMATION SHOULD ONLY BE RELEASED TO:***

Contact Person or Organization/Capacity:

NAME: **PHONE:**

ADDRESS: **FAX:**

- **I authorize _____or his/her administrative staff to release the following information to New Leaf Counseling of 929 S. Washington St, Junction City, KS 66441:**

□ *Evaluation* □ *Progress Notes* □ *Verbal communication* □ *Admission Summary*
□ *Complete Chart* □ *Discharge Summary* □ *Treatment Summary* □ *Other:*_____

- ***PURPOSE OF DISCLOSURE:***

□ *Evaluation/Treatment Planning* □ *Continuation of Treatment*

□ *Case coordination* □ *Legal Proceedings* □ *Other* _____

I understand the information to be released may include psychiatric, psychological, therapeutic, and/or other medical information. It may also include school and legal information. This information may be released by mail, fax, or telephone. I understand I have the right to revoke this authorization in writing, at any time by sending such written notice to my therapist's office address. I understand that my revocation of this release will not be effective in cases where the therapist has used the initial authorization of information as a condition of obtaining insurance coverage. I understand I have a legal right to contest a claim. I understand that my therapist generally may not condition therapeutic services upon my signing an authorization unless the therapeutic services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and no longer protected by HIPAA Rule. The confidentiality of this information is protected by Federal Regulations and/or Kansas Statutes. Federal Regulation 42CFR Part 2 prohibits any further disclosures of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.

- **This authorization shall remain in effect until 30 days after termination of treatment unless otherwise specified: _____**

Signature of Client or Legal Representative _____ Date:_____

Signature of Witness_____ Date:_____