



Authorization Release Form

This authorization is required by the Health Insurance Portability & Accountability Act (HIPAA) of 1996 to inform you of your rights for privacy with respect to your health care information. It authorizes **New Leaf Counseling Services, LLC**:

- Release records to, relating to
 Obtain records from, relating to

Patient Name:	DOB:
Individual/Company Name:	
Address:	
Phone:	FAX:

Information to be released: (please check)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Medication List | <input type="checkbox"/> Initial/Update Assessment | <input type="checkbox"/> Treatment Plan(s) |
| <input type="checkbox"/> Termination/Discharge | <input type="checkbox"/> Summary of Tx Letters | <input type="checkbox"/> Dates of Service | <input type="checkbox"/> Compliance |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> NLCS Consult | | |

Information to be obtained: (please check)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Therapy Notes | <input type="checkbox"/> Initial/Update Assessment | <input type="checkbox"/> Treatment Plan(s) |
| <input type="checkbox"/> Compliance | <input type="checkbox"/> Termination/Discharge | <input type="checkbox"/> Medication List | <input type="checkbox"/> Dates of Service |
| <input type="checkbox"/> Psychological/Academic Testing Reports | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> NLCS Consult | <input type="checkbox"/> Educational Plans |

This authorization is in effect until _____

Purpose for Disclosure *Coordination/Continuation of Care* *Legal* *Insurance* *Patient's Own Use*

- I consent to this authorization release designated above. I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), alcohol/drug abuse (42 CFR Part 2), and/or HIV/AIDS test results or diagnoses (ORC3701.24.3).
- I understand that by disclosing these records, the practice cannot guarantee the recipient will not re-disclose or use the records in violation of the Privacy Rules.
- Under the privacy rules I have the right to revoke this authorization at any time in writing and New Leaf Counseling Services, LLC must cease using this authorization. However, the practice may complete any action it initiates with my PHI prior to my revocation which rely on the above records for completion. (For example: an insurance company relying on the record to contest a claim).
- Please submit record requests to New Leaf Counseling Services, LLC via fax (833) 450-0400. If fax is not available, please mail requests to New Leaf Counseling Services, LLC 215 Miller Road, Suite 7 Avon Lake, Ohio 44012

Patient Signature _____ Date _____

Guardian Signature _____ Relationship to patient _____ Date _____

Witness Signature _____ Date _____

STOP HERE UNLESS YOU ARE REVOKING AN ALREADY SIGNED RELEASE

I am revoking an already signed Authorization above

Patient Signature _____ Date _____

Guardian Signature _____ Relationship to patient _____ Date _____

Witness Signature _____ Date _____