A New Day Counseling & Family Wellness, Inc. NFP
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Authorization for Release of Confidential Information

Client Name: ______________________ Date of Birth:______________

I authorize ____
(service provider/therapist)

to disclose the following information to: ____
(name and address of person or title of person or organization)

from______________ through the present: (**client MUST initial each item to be disclosed**)

___ Assessment
___ Diagnosis
___ Psychosocial Evaluation
___ Psychological Evaluation
___ Treatment Plan or Summary
___ Current Treatment Update
___ Presence/Participation in Treatment
___ Nursing/Medical Information
___ Continuing Care Plan
___ Educational Information
___ Discharge/Transfer Summary
___ Progress in Treatment
___ Demographic Information
___ Other: _________________________

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: ____________________.

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to your therapist. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. Unless sooner revoked, this consent expires on the following date: ___________.
If a calendar date is not stated, information may only be released on the date the authorization is received.

I further understand that my service provider will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: ____ .

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically. State and Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 or the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1 *et. seq*.).

I understand that I have the right to inspect and copy the information to be disclosed. A copy of this authorization will be available to me for my records.

____ ___________
Signature of Adult or Minor Recipient between the ages of 12 and 17 Date

____ _________________________ ___________
Signature of Parent, Guardian or Personal Representative Print Name Date
If you are signing as a personal representative of an individual, describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.
____

____ _________________________ ___________
Signature of Witness Attesting to Identity and Authority Print Name Date