NEW LEAF COUNSELING, LLC

Authorization For Disclosure Of Mental Health Treatment Information

I, _____[Insert Name of Patient/Client],

whose Date of Birth is _____, authorize New Leaf Counseling, LLC to disclose to and/or

obtain from: _____

the following information: [Insert Name of Person or Title of Person or Organization] Description

of Information to be Disclosed (Patient/Client should initial each item to be disclosed)

_____ Assessment
_____ Psychosocial Evaluation
_____ Psychiatric Evaluation
_____ Current Treatment Update
_____ Presence/Participation in Treatment
_____ Educational Information
_____ Continuing Care Plan
_____ Demographic Information
_____Other_____

_____Other_____

_____ Diagnosis
_____ Psychological Evaluation
_____ Treatment Plan or Summary
_____ Medication Mngt. Information
_____ Nursing/Medical Information
_____ Discharge/Transfer Summary
_____ Progress in Treatment
_____ Psychotherapy Notes*
*cannot be combined with any other.

Purpose

This information may be used or disclosed in connection with mental health treatment,

payment, or healthcare operations. If the purpose is other than as specified above, please

Specify: _____

_____

311 Depot Street, Suite M
Antioch, Illinois 60002
www.newleaf-counseling.com

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Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to New Leaf Counseling, LLC., 311 Depot Street, Suite M, Antioch, Illinois 60002.. 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.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____,

or as otherwise indicated:_____.

Conditions

I further understand that New Leaf Counseling, LLC. 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: _____

_____.

Form of Disclosure

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.

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Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections. I will be given a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, health care surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

_____

Signature of Staff Witness Date