A New View Counseling & Consulting, LLC
10945 Reed Hartman Hwy, Suite 203
Blue Ash, Ohio 45242

Authorization to Use and Disclose Information

Name of Client: _____
Last **First** **Middle**

Date of Birth: _____ **Phone:** _____

Address: _____

City/State: _____ **Zip Code:** _____

I hereby authorize the Provider to use and disclose the information indicated below to:

Name: _____

Address: _____

Phone: _____ **Fax:** _____

Email: _____

Information may include (check all that apply):

[ ] Personal Identifying Information (including Demographic Information)
[ ] Developmental and/or Social History (Family History, Substance Abuse, etc.)
[ ] Mental Health Evaluations
[ ] Assessment , Diagnosis, and Treatment Plan
[ ] Progress Notes, Treatment Reports, and/or Discharge Summary
[ ] Educational Records
[ ] Other: _____

Information may be:

[ ] Mailed
[ ] Reviewed Only
[ ] Picked up: _____

Relationship to the Client:

[ ] Self
[ ] Parent or Legal Guardian
[ ] Other Responsible Party: _____

Purpose for the use and disclosure (check all that apply):

[ ] Treatment Planning and Assessment
[ ] Changing Provider, Second Opinion, and/or Continuing Care
[ ] Legal
[ ] Personal
[ ] School
[ ] Payment, Insurance, and/or Workers' Compensation
[ ] Other

I understand and agree as follows:

a. If I am receiving treatment related to mental health or substance abuse, I authorize the Provider to use information maintained by Heather Everett, MSW, LISW-S,~~Amanda D. Graves, MSW, LSW~~ at A New View Counseling & Consulting, LLC to obtain payment for services rendered and to use and disclose my information, including but not limited to my Protected Health Information, to obtain payment from such entities for services rendered;

b. I am aware that this information is confidential and may be protected pursuant to Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164); Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2); as well as any relevant state laws. Furthermore, I acknowledge that the information provided to the assignee may not be protected under these guidelines if receiver is not a health care provider covered by state or federal laws;

c. **I understand this Authorization is voluntary and may be rescinded at any time via written request to** 10945 Reed Hartman Hwy Suite 203, Blue Ash, Ohio 45242. Otherwise, **this consent will automatically expire one year from today's date;** and

d. I am entitled to a copy of this authorization upon request and I have been informed of my right to refuse to sign this authorization.

[ ] Check here if Authorization is NOT given.

The Provider will not condition treatment or payment on this Authorization. Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protect by applicable laws, rules, and regulations.

Prohibition on Re-disclosure:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit further disclosure of this information without the express written consent of the Client or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical and/or other information is NOT sufficient for this purpose. Federal rules restrict use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature of Client: _____
Date: _____

Signature of Parent, Guardian or Responsible Party of a Client who is a Minor:
_____
Date: _____

Witnessed by: _____
Date: _____