"Offering a New Vision to Meet Your Life's Destiny"

RELEASE OF INFORMATION

I, ____, do hereby authorize
______________________________ or any related representative at New Vision Counseling Center, LLC to

release receive exchange

information concerning _________________________________ (Name of Client, DOB)

to from with _________________________

I understand that such disclosure will be made for the following purposes:

Treatment Progress
Psychiatric Evaluation
Child Custody / Visitation
Treatment Planning
Social History
Competency to stand trial
Medical Treatment
Treatment Summary
Other __________________
Reimbursement for Treatment
Diagnosis

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time by giving written notice to Kristy Christopher, LPC

If no prior notice of revocation is received, this consent will expire automatically two (2) years after the date indicated thereon.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I have read, or had read to me, the above, and understand the contents.

________ I authorize this information to be faxed to the party indicated above, and
Initial understand the limits of confidentiality which doing so creates.

____ ___________________
Signature of client, parent, or legal guardian Date

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