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.

________ I have received and read the ROI, however at this time, I do not have anyone I wish to release
Initial information to. I am aware that I can make additions/changes as necessary and at anytime by completing this form.

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