A NEW YOU COUNSELING SERVICES PLLC
HELPING TO TRANSFORM MINDS, HEARTS, AND LIVES.

5135 Morganton Road, Suite 103, Fayetteville, NC 28314
Phone: 910-797-4404 Fax: 910-240-9783

AUTHORIZATION TO OBTAIN/RELEASE INFORMATION FORM

Client Name: _____ DOB: _____Last 4 SS#:_____

I hereby authorize A New You Counseling Services, PLLC, Dawn Shea-Frick, LCMHC, LCAS to:

(**Initial one or both**): _____ Obtain from the following _____ Release to the following

Name: _____

Address:_____

Phone: _____ Fax: _____

Date of Service: All _____ **(Initial)** or For these dates only (__/__/____ to __/__/____) ____

The releasing/obtaining of information may be documented records or verbal communication for the following purpose: _____

and may include the following: **(Please Initial)**

____ Therapist Notes ____Alcohol/Substance Use ____Intake/Diagnosis

____ Discharge Summary ____Summary of Treatment (goals, progress, outcomes, barriers) ____ ALL

I understand that my records are confidential and cannot be released without my written authorization, except as otherwise provided by law. I understand this authorization will remain effective for 365 days from the date of my signature and that information will be handled confidentially and in compliance with all applicable federal laws. I understand that information regarding any alcohol and /or drug treatment is protected by federal law under HIPAA, See generally 42 C.F.R Part 2; 45 C.F.R Parts 160, 164. I understand that I may revoke authorization at any time by written, dated communication; except to the extent that action has already been taken in reliance upon it. I have read and understand the nature of the release.

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness/Guardian Date

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Instructions for Completing Authorization to Obtain/Release Information Form:

1. Write your full legal name, DOB and last four of your social security #

2. INITIAL whether provider can obtain information from or release information to. Be sure to use initials.

3. Write the full name and address of the company/organization AND the person with whom the information should be sent/or shared with. Write the phone number and the fax number where this company/organization and person can be reached for releasing/ obtaining.

4. INITIAL whether you are releasing information pertaining to ALL of the dates of service for which you were seen (your complete record) or the specific dates (if the release is limited to specific dates of service).

5. Write in the purpose for the release of information being specific. For example, "all information contained in record for social security disability evaluation."

6. INITIAL what information can be shared. If you are needing to release whatever is necessary to a third party (ie Social Security) you will want to initial ALL. If you only want information released pertaining to your diagnosis for example, initial that. Please be aware if information beyond what you have released is requested you may need to complete a new release.

7. Complete Signature and Date