New Path Counseling LLC

P.O. Box 241171
Apple Valley, MN 55124
newpathcounseling.net
(612) 239-3516

Release of Information

ORIGINAL TO CLIENT FILE

I, _____ (birth date: ___/___/___), authorize New Path Counseling LLC
(Print full name)

_____ a. **Obtain information from**

And/or

_____ b. **Release information to** _____
(Name of agency. NOTE: Use a separate release for each organization)

This information exchange will be helpful to either or both agencies in providing services to me, including such information as:

_____ No restrictions _____ Assessment at intake/admission _____ Discharge summary
_____ Psychological evaluation _____ Progress notes _____ Service/treatment plan
_____ Other (specify) _____

I understand that this authorization is **in effect for one year** from the date of my signature or until _____. (Leave blank if one year)

I understand that **I can revoke this consent** at any time--except to the extent that action has already been taken based on it--by making a written, dated request to New Path Counseling LLC.

I understand that the information will be **handled confidentially** by New Path Counseling LLC in compliance with all applicable federal laws.

I have **read and understand** the nature of this release.

DATE: _____ Client signature: _____

WITNESS: _____
New Path Counseling LLC staff or other witness must sign or print legibly

Parent/guardian/authorized representative:

_____

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.