NEW ROOTS
counseling

Release of Information

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Client Name:_____ **Date of Birth**_____

Address (street, city, state, zip)_____

I _____**, hereby authorize: New Roots Counseling or therapist**_____

And **Name**_____
Address_____
Phone_____ **Fax**_____
Relationship to client _____

TO DISCLOSE TO AND COMMUNICATE TO ONE ANOTHER information contained in my patient/student records, including if any, alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Par 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA); social services records; psychological services records, including communications made by me to a social worker or psychologist; and all information defined by statute and SC Department of Public Health Rules governing Human Immunodeficiency Virus (HIV), HIV Test, Acquired Immunodeficiency Syndrome (AIDS), and AIDS-related complex (ARC), only under the conditions listed below:

SPECIFIC INFORMATION TO BE DISCLOSED

☐ COMPLET COUNSELING MEDICAL RECORD	☐PROGRESS REPORTS	☐REAUTHORIZATION FORMS
☐ASSESSMENT/DIAGNOSIS	☐RECOVERY PLAN	☐OTHER PERTINENT INFORMATION (Specify)_____
☐COMMUNICATION EXCHANGE	☐DISCHARGE SUMMARY	_____
☐PSYCHOSOCIAL/COUNSELING RECORD	☐DR. DISCHARGE SUMMARY	_____
☐TREATMENT PLAN/CONTRACT	☐_____	_____
☐LAB RESULTS	☐_____	_____
☐ADMISSION/DISCHARGE DATA SET	☐_____	
☐SCHOOL/WORK RECORDS	☐_____	Dates of Service_____
☐SCHOOL/WORK SOCIAL INVOLVEMENT	☐_____	

PURPOSE AND NEED FOR SUCH DISCLOSURE

☐CONTINUATION OF CARE	☐_____	☐RETURN TO SCHOOL/WORK
☐SCHOOL/WORK	☐_____	☐OTHER (Specify)_____
☐REFERRAL FOLLOW-UP	☐_____	_____
☐FAMILY NOTIFICATION		

I understand that my medical record may contain reports, test results, and notes that only a care provider can interpret. I understand and have been advised that I should contact my care provider regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold New Roots Counseling, or counselors liable for any misinterpretation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation. I understand that generally my treatment may not be conditioned on whether or not I sign an authorization form, but that in certain limited circumstances, I may be denied treatment if I do not sign an authorization form. This authorization is subject to a written revocation at any time except in those circumstances in which New Roots Counseling has taken certain actions in reliance on such authorization. However, this authorization shall be valid no longer than is reasonably necessary to accomplish the purpose of the actions for which it was given. The information may be released in written form, as copies of existing records, or by written or verbal report, either in peron or by telephone, and may be sent throught the mail or provided fax transmission. This authorization will automatically expire 12 months from the end of involvement in therapy with New Roots Counseling or as specified in the revocation below. A photocopy of this signed release is considered valid as the original.

_____ _____ _____ _____
Signature **Date** **Witness** **Date**

_____ _____
Parent or Guardian Signature (if the client is a minor) **Relationship to Child**

Initial_____ **If the client is a minor or incapable of signing, a copy of the appropriate legal documentation is attached if applicable.**
Initial_____ **If I have joint custody, I have discussed this matter with the other legal guardian(s).**

_____ _____
Parent or Guardian Signature (if the client is a minor) **Relationship to Child**

☐DRIVERS LICENSE/IDENTIFICATION VERIFIED
☐ REVOCATION (optional) – This authorization is revoked for the following specified dates, events, or conditions.

Date_____ Event_____ Condition:_____