



20 N. Barbara St., Suite A, Mt. Joy, PA 17552 Phone/Fax (717) 653-1507

I, \_\_\_\_\_, hereby authorize New Life Counseling Services to:

Print name of Client or Representative

a) send to and/or b) receive from

Agency or Person

Address

Phone

written or verbal confidential and privileged information regarding:

Client's Name

Date of Birth

Social Security Number

The following mental health information and/or records may be released:

and will be used for the purpose of:

I understand that: a) this information may be protected by federal, state or local law, and that I have no obligation to disclose this information; b) I may revoke this Authorization by notifying New Life Counseling in writing at any time, except to the extent that information has been released already in reliance hereon; c) this Authorization may be less restrictive than the Consent already in effect; and d) I may receive a copy of this Authorization, and a copy of this Authorization will accompany the released information provided to the aforementioned person or agency. Having read or having had it explained to me, I understand fully the contents and purpose of this Authorization.

Client or Representative Signature

Date

Witness Signature

Date

My signature above also verifies that the Client received adequate explanation to make an informed decision

Description of Representative's Authority to Act for Client

This Authorization will expire on \_\_\_\_\_, or one year after the date of execution, whichever comes first.

Date/Event

Verbal Authorization

The undersigned verify that verbal authorization for release of the above confidential information has been given. The client or parent/guardian was fully informed of the information contained herein and understood its nature and the intended use of the released information

Witness Signature

Date

Witness Signature

Date

NOTICE TO RECIPIENT: The aforementioned information is disclosed to you from records whose confidentiality is protected by State and Federal statute. State and Federal regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains.

NOTICE TO CLIENT: The information hereby released may be subject to re-disclosure by the recipient and may no longer be protected by the rule that requires this Authorization. In addition, Federal regulation prohibits further treatment being conditioned on your signing this Authorization.

A mental health facility receiving a request for information from a governmental agency may accept that agency's Authorization to Release Information form if it is signed by the client/parent/guardian responsible for the control of information, unless the client/parent/guardian has specifically expressed opposition to that agency's receiving information.