NEW DIRECTIONS
COUNSELING SERVICES, LLC
WEXFORD • ROBINSON

Authorization to Release Information

Client Name: _____ Date of Birth: _____

I authorize New Directions Counseling Services, LLC (NDCS) to:

❑ **Release my information** ❑ **Obtain my information** ❑ **Exchange my information**

The sensitive and pertinent information that will be released to, obtained from, or exchanged with another party will include:

❑ **Verbal description of treatment** ❑ **Letter or email detailing treatment** ❑ **Treatment notes**
❑ **Psychological report** ❑ **Medical records** ❑ **Blood work reports**
❑ **Academic records** ❑ **Legal records**
❑ **Other: _____**
❑ **All Mental Health Records (**including ❑ **Medication Management Records)**

***I authorize NDCS to obtain information from another party that includes treatment from this date _____ to this date _____ and please fax these relevant records to New Directions Counseling Services, LLC at* 724-934-3906.**

I am requesting that NDCS release, obtain, or exchange my information for the following reasons:

❑ **Coordination of care** ❑ **Facilitation of medical, psychological, or educational evaluation**
❑ **Legal proceedings** ❑ **Disability or worker's compensation claim**
❑ **Other: _____**

***I authorize NDCS to release, obtain, or exchange my information with the following party* (please complete thoroughly):**

Name of Individual or Institution: _____
Relationship to Client: _____
Mailing Address: _____
_____
Email Address: _____
Phone Number: _____
Fax Number: _____

This authorization shall remain in effect unless it is revoked by you, in writing, at any time by sending such written notification to our compliance officer, Dr. Michael Schneider, at mschneider@newdirectionspgh.com. Please note that we cannot revoke this authorization to the extent that we have already relied on this authorization to release, obtain, or exchange information, and if this authorization is a condition of obtaining insurance coverage, the insurer has a legal right to contest your claim to revoke this authorization.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient of your information and is no longer protected under the conditions of our Privacy Practices.

_____	_____	_____
Printed Name of Client (or legal guardian/rep)	**Signature of Client (or legal guardian/rep)**	**Date**
_____	_____	_____
Printed Name of Minor Client (if age 14-17)	**Signature of Minor Client (if age 14-17)**	**Date**
_____	_____	_____
Printed Name of Witness	**Signature of Witness**	**Date**

