NEW DIRECTIONS
MENTAL HEALTH
A MEMBER OF TRANSFORMATIONS CARE NETWORK

AUTHORIZATION TO RELEASE INFORMATION

Client/Patient Name: _____ Date of Birth: _____

Client/Patient Complete Mailing Address: _____

I authorize New Directions Mental Health to:

☐ Release my information ☐ Obtain my information ☐ Exchange my information

Name of Individual or Facility: _____ Relationship to Client/Patient: _____

Complete Mailing Address: _____

Phone Number: _____ Fax Number: _____ Dates of Service/Treatment: _____

I am requesting that **New Directions Mental Health** release, obtain, or exchange my information for the following reasons: ◉ Coordination of Care ○ Other _____

The sensitive, pertinent information will be released to, obtained from, or exchanged with another party will include: X Medication Report *(Select all others that apply)*

☐ Psychiatric Evaluation ☐ Inpatient Records ☐ Academic Records ☐ Treatment Notes ☐ Medical Records ☐ Discharge Summary
☐ Blood Work/Lab Rpts ☐ Verbal Communication ☐ Written Communication ☐ Diagnosis Letter ☐ Other _____

☐ **I Authorize the Release of All Mental Health Records -** *I acknowledge that my mental health records may include information regarding the use and/or abuse of drugs and alcohol and related treatment. I authorize the release of my mental health records including the references to the use and/or abuse of drugs and alcohol.*

Authorization Expires: 1 Year From Date of Signed Authorization OR ☐ Other Date if Less than One (1) Year: _____

Please fax these relevant records to New Directions Mental Health at _____.

This authorization shall remain in effect for one year or less. Revoking this authorization must be done in writing. 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-disclose by the recipient of your information and is no longer protected under the conditions of our Privacy Practices. ***Please Note: When requesting records from a hospital, approximate dates of service must be specified.***

Client/Guardian Full Name	Client/Guardian Signature	Date

If signed by client/patient representative, please state your relationship to the client/patient. _____