AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Date:__________________

I hereby authorize **New Growth Counseling Services** to use, obtain, and/or disclose the protected health information of the following individual:

Last name:	First name:	Middle initial:
Street Address:	City/State:	Zip:
Telephone:	SSN:	Date of Birth:

This information may be obtained from or released to the following individual or entity:

Last name (or entity):	First name:	Middle initial:
Street Address:	City/State:	Zip:
Telephone:		

Purpose of request:____

____

Sensitive information: I understand that the information in my record may include information about behavioral or mental health services or treatment for alcohol and drug use. It may also include information relating to sexually transmitted diseases, and or HIV/AIDS.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that was released prior to revocation.

Photocopy or Fax: I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:____
If I do not specify an expiration date, event, or condition, this authorization will expire in one (1) calendar year from the date it was authorized.

Re-Disclosure: If I have authorized the disclosure of my PHI to someone who is not legally required to keep it confidential, I understand that it may be re-disclosed and no longer protected. I also understand that I cannot hold New Growth Counseling Services responsible for information re-disclosed by another person or party.

Other Rights: I understand that authorizing the disclosure of my PHI is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the PHI to be used or disclosed as provided in 45 Code of Federal Regulations section 164.524.

I have the right to receive a copy of this authorization – **I want a copy of this form YES / NO**

Signature of client:	**Date:**
Signature of Parent/ Guardian:	**Date:**
If signed by legal representative, relationship to client:	**Date & signature of person validating identification:**