New Leaf Counseling

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Authorization for Use or Disclosure of Protected Health Information

Client Information:

Client Last Name:__________________________ First Name:_____________________ MI:_________

DOB:_________________

Client Address:____

Phone Number:______________________________________

E-mail Address:____

Recipient Information

I, ____, do hereby authorize **NEW LEAF COUNSELING, GAYLE WHITLOCK, LMFT**, to release a copy of my mental health information to the person or facility listed below:

Name of person/facility to receive medical information:____
____

Phone Number:____

Address:____
______

Date of Authorization: ____________________

Authorization to expire on ______________________ or upon the happening f the following event:____
____
____

Information to be Released: (*Note: Requests for release of psychotherapy notes cannot be combined with any other type of request*.)

□ My entire mental health record

□ Only those portions pertaining to:
____
____

(Specific provider name and/or dates of treatment)

□ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

□Other:____
____
____

Purpose of Information Release:

□Further mental health care

□Applying for insurance

□At the request of the individual

□Payment of insurance claim

□Vocational rehab, evaluation

□Legal investigation

□Disability determination

□Other
(specify):____

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.