AUTHORIZATION FOR RELEASE/EXCHANGE OF CLIENT INFORMATION

Client: _____Date of Birth:_____

I hereby authorize New Transitions Counseling Center, Ltd. to release information to the person(s)/organization(s) listed. I understand that this authorization is voluntary and refusals to consent to release will not effect my treatment, except for any impact not releasing/exchanging the information might have. I have the right to inspect and copy the information disclosed (except under certain circumstances where information was received from a minor under the promise of confidentiality). I also understand that my information is protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164) and/or state laws. I understand that any re-disclosure of my information by the recipient is not under the control of New Transitions Counseling Center. If the person(s)/organization(s) are not a healthcare provider, the released information may no longer be protected by the Federal privacy regulations.

1. **Person(s) to whom disclosure/exchange is to be made (including organization affiliation and contact information if applicable)**

   _____

   _____

   Phone:_____Attention:_____

2. **Specify type of information to be released/exchanged:**

   ☐ Diagnosis ☐ ☐
   ☐ Attendance ☐ ☐
   ☐ Progress ☐ ☐
   ☐ Other:_____

3. **Mode of communication approved:**

   ☐ Written (report/letter) ☐ Verbal (phone call or Face-to-face)

4. **The purpose for release/exchange:**

   ☐ Continuity of Treatment ☐ Aftercare Planning
   ☐ Referral ☐ Consultation
   ☐ Family Involvement ☐ Other:_____

If the client is a minor, the custodial parent/legal guardian must sign this consent form. If the client is at least 12 years of age, but under 18, the client must sign in addition to his/her parent/legal guardian. Further, as the parent(s)/legal guardian(s) appointed pursuant to 705 ILCS 405/2-27, I am authorized to act on behalf of the identified minor, and I hereby consent to this limited disclosure under the terms stated above. The parent(s)/legal guardian(s) is the legal representative of the unemancipated minor, pursuant to HIPAA, 45 CFR 164.502(g), unless otherwise required by law.

Expiration Date: ____/____/_____ Event: _____ Condition: _____

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Date

_____ _____
Witness/ Representative of Counseling & Diagnostic Center Date

I understand that I may revoke this authorization in writing at any time and, except for information disclosed prior to revocation, further disclosure will cease. I also understand that changing my mind will not effect my treatment except for any impact of not releasing the information.