NewHope
COUNSELING

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CONSENT & AUTHORIZATION TO RELEASE CONFIDENTAL INFORMATION

I, _____(participant), hereby consent to communication, either to release or obtain information during the course of participation in an evaluation &/or treatment program, between New Hope Counseling & the following individuals and/or agencies (please include contact information):

1. _____

2. _____

Or their designee within the same entity(ies)

This includes, but is not limited to, the following information:
-Current legal status & past legal history
-Current & past medical status including, but not limited to diagnosis, medications, prognosis, & treatment
-Current mental health, substance use, domestic violence, &/or anger management treatment including, but not limited to, modality of treatment received & current treatment plans
-Mental health, substance use, domestic violence, &/or anger management history including, but not limited to, treatment, hospitalizations, inpatient treatment, & outpatient treatment
-Relevant information pertaining to your biological, psychological, &/or sociological history
-All results of my evaluation & the screening tools & collateral information used to determine my level of care

I understand that the purpose of this communication is to determine program appropriateness & to assist in the proper coordination of effective treatment recommendations. I understand that the information I provide during my evaluation & any collateral information that is gathered with my written permission will be considered when discussing my case.

I understand that, if accepted into a program, this consent will remain in effect throughout the duration of my participation & will remain in effect for 6 months beyond the completion or termination of my program. I understand that continued communication about my participation, attendance, drug screen results, completion or terminations will occur. However, please note that treatment, payment, or eligibility for any applicable benefits is not conditioned upon your signing this authorization, & you have the right to refuse to release information to anyone.

Please indicate your preference regarding the information to be shared by signing your initials:

_____The individuals &/or agencies above may discuss my medical &/or mental health/substance use/domestic violence/anger management/other workshop information without limitation, as previously listed.

_____I would prefer to limit the information shared between the individuals &/or agencies stated above. The limitations I would like to make are as follows:

_____

_____

Additionally, please indicate if the following is applicable with your initials:

_____If I am a minor, my parent/guardian/court-ordered custodian and I both must initial here in order for this information to be released.

_____I authorize the disclosure of information, if any, concerning testing for HIV (human immunodeficiency virus) and/or treatment for HIV or AIDS (acquired immune deficiency syndrome) and any related conditions.

I understand that my records are protected under the federal regulations governing the Confidentiality of Alcohol & Drug Abuse Patient Records, 42 CFR Part 2 & under HIPAA statutes, & cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that the information disclosed through this Authorization may be subject to re-disclosure by the recipient and is then no longer protected by federal privacy regulations or other applicable state or federal laws. Anyone that violates your rights to confidentiality may be reported to the United States Attorney and be subject to criminal penalties.

Your signature below indicates that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that this release will remain in place throughout the duration of your treatment & an additional 6 months after your completion or termination from this program. Your signature also indicates that you are aware that any cancellations or modifications of this authorization must be in writing, & that you have the right to revoke this authorization at any time unless New Hope Counseling staff has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing & received by New Hope Counseling staff in order to be effective.

Signature of Client or Authorized Guardian Date

Printed Name of Client or Authorized Guardian (relationship) Client Date of Birth

Signature of Witness Date

Printed Name of Witness