New Heights Counseling Services, LLC
663 Park Meadow Dr., Suite A
Westerville, Ohio 43081

Date ____________________

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Client Information					
Last Name		First Name			Initial
Address		City	Sate		Zip
Date of Birth	Soc. Sec. Num.		Phone		

☐ I hereby authorize the Agency/Individual listed below to release the information checked below to New Heights Counseling Services, LLC.

☐ I hereby authorize New Heights Counseling Services, LLC to release the information checked below to the listed agency/individual.

Agency or Individual Information		
Agency or Individual Name		
Street Address		
City	State	Zip

Information to be Released		
☐ Clinical Diagnosis	☐ Initial Evaluation	☐ Psychosocial Summary
☐ Drug/Alcohol Information	☐ Psychiatric Evaluation	☐ Recommendations
☐ Educational Information	☐ Psychological Testing	☐ Treatment Summary
☐ Individual Treatment Plan	☐ Other:	

For the purpose of: ☐ Medical Care / Treatment ☐ Insurance ☐ Other: ____________________________

I understand that:

1. By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
2. I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
3. I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
4. If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. New Heights Counseling Services and any of it's representatives shall not be held liable for any consequences resulting from re-disclosure.
5. Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released.
6. A copy of this signed form will be provided to me.
7. NHCS may charge an administrative fee to cover the cost of labor, copying, and postage. The counselor will inform me of any charges and arrange for payment.
8. This Authorization expires on _______________________________ (If date not completed / 90 days after signed).

____
Client / Representative Signature

____
Printed Name of Representative if not client

____
Counselor Signature

____
Relationship to Client