NEWMAN AVENUE ASSOCIATES
RELEASE OF INFORMATION

TO: _____

_____

_____

This is my request that you provide information regarding me and/or my child. Below you will find my consent for disclosure (exchange/release) of this protected health information. Thank you for your attention to this request.

Name:		***Social Security #***	
DOB:			

I _____ ***Authorize*** _____

to disclose (exchange/release) protected health information in my records as indicated below:

☐	Records of outpatient treatment.	
☐	Records of hospitalizations and inpatient treatment,	
☐	All diagnostic, psychological and other information in my file,	
☐	Educational testing, school records, etc.	
☐	Psychotherapy notes	
☐	***Other***	

With or To:

Purpose:

I have been informed of my right **not** to authorize this disclosure and my right to revoke this consent in writing at any time by sending such written notification to the practice Privacy Officer. I understand that a revocation is not effective to the extent that my treatment provider has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization could possibly be disclosed by the recipient (if not required by HIPAA to keep it confidential) and may no longer be protected by federal or state law. If not otherwise specified, this release will expire one year from the date signed below.

Client Signature:	***Date:***
Parent/Guardian/Personal Representative Signature:	***Date:***
Therapist Signature:	***Date:***