NewSong Counseling Center

425 N Maysville Street, Mt. Sterling, KY 40353 (859)-497-0594

AUTHORIZATION FOR RELEASE OF INFORMATION

1. The undersigned hereby request and/or authorize:
   NewSong Counseling Center 425 N. Maysville Street, Mt. Sterling, KY 40353

to release medical record of:

Name:	SS#
Birth Date: / /	
Address:	Phone:
City:	
State: Zip:	

2. Information to be released to: Unless you are providing treatment to the client, you must specify name of an individual NOT a law firm, court, office, etc. If additional space is needed, add individual names on Addendum A. Check the "Yes" box if additional names are included on Addendum A or "No" if there are no additional names ❑Yes ❑No
   Name of Person or Agency: _____
   Address: _____
   City:_____State:_____ Zip _____

3. Information to be released – check 'yes' or 'no' AND initial.
   (May include substance use disorder records, if applicable)

Yes	No	Information Authorized to Release	Initials		Yes	No	Information Authorized to Release	Initials
		Major Evaluations					Medications	
		Treatment Plans					Progress Notes	
		Appointment History					Other:	
		Doctor Notes						

4. Purpose of Release (coordination of care; information; continuity of care, etc.):

Time limitation of Release: This consent is subject to revocation at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization.

This authorization expires one year from date of signature or the following date _____/____/_____ or
Event Termination of Services (not to exceed one year).

Prohibition on redisclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and/or KY State Law. The Federal rules and/or KY state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and/or KY state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

_____ _____
Date Signature of Client/Resident/Patient

_____ _____
Witness Signature of Client's/Resident's/Patient's Agent or Representative

This form must contain original signatures.

Relationship: _____
Address: _____

City: _____State:_____ Zip:_____

COMPLETE BELOW ONLY IF THE CONSUMER WISHES TO REVOKE ABOVE AUTHORIZATION

I, _____ wish to revoke this authorization.

_____ _____
Date Signature of Consumer, Guardian, or Authorized Representative

_____ _____
Date NewSong Counseling Center Witness

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ADDENDUM A

2. Information to be released to (Continued): Unless you are providing treatment to the client, you must specify name of an individual NOT a law firm, court, office, etc.