

Center for New Beginnings

Release of Information Form

By signing this Authorization form, I authorize the use or disclosure of my individually identifiable information maintained by:

Name: _____

Address: _____

My information may be disclosed under this Authorization to the following recipient:

Name: _____

Address: _____

Educational and/or health information includes information collected from me or created by the Provider, or received by the Provider in the past. Information may relate to my past, present or future educational, physical or mental health condition, or the provision of care.

Information that may be used or disclosed through the Authorization is as follows:

- All educational and/or health information about me, including my clinical records, created or received by the Provider.
- All information about me, except _____
- Only specific information about _____

This Authorization is in effect for 12 months from the signature date: _____

I understand that the Center for New Beginnings cannot guarantee that the recipient will not re-disclose information to a third party. The recipient may not be subject to federal laws governing privacy of information. I understand that I can refuse to sign a release of information form without being refused treatment or services.

I understand that I may revoke authorization at any time with a written signature. I have read and understand the terms of this authorization. I have had an opportunity to ask questions about the use of disclosure.

Client Signature/ Legal Guardian: _____

Print Full Name of Client: _____ Birth date: _____

Date: _____