**New Life Counseling Center, PLLC**
**3410 Healy Drive, Suite 207**
**Winston-Salem, NC 27103-1568**
**Founder/Owner: Donna P. Dunlap, MSCP, LPC**


# CONSENT FOR RELEASE OF INFORMATION

I authorize the release of information to and from New Life Counseling Center, PLLC and:

______________________________________________________________________
(Name of care provider(s) and contact information)

The following information:

- ☐ Whether the client is in treatment or not…
- ☐ Prognosis (diagnosis, opinion of how treatment will benefit client, general peculiarities of case)
- ☐ Nature of past services (Type of interventions offered, purpose and philosophy of program)
- ☐ Brief statement regarding progress (client's denial, client's understanding of their condition and the disease concept, progress or lack of progress on goals, cooperation with treatment plan and rules)
- ☐ Brief statement regarding relapse and frequency of relapse (cannot identify specific drugs)
- ☐ Psychological Evaluation and Testing Results
- ☐ Clinical Impression/Diagnosis
- ☐ Other________________________________________________________

Regarding: _____________________________________ DOB: ____________________
Name of client(s)

May be given for the purpose of: ______________________________________________

______________________________________________________________________

This release is signed with the understanding that this information will not be re-released without my written informed consent nor be used for any other purpose than specified above. This release may be revoked by me at any time in writing and shall be valid for not more than one year from the date below. All released information will be protected in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Signature: _____________________________________ Date: __________
(Client, parent, guardian, or Power of Attorney)

Witness: ______________________________________ Date: __________


*Office phone: (336) 793-7005* *Fax: (336) 923-2001* *email:* donna@newlifecounsel.com

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.
6. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records