New Leaf Alternative DBA
Counseling Service Authorization
&
Release of Confidentiality

Client name_____

I authorize New Leaf Alternative here to fore known as NLA and all persons, entities listed below or their representatives, to mutually release and disclose my health information.
I have received and reviewed NLA's Notice of Privacy Practice form.

I understand that by signing this general authorization I am authorizing NLA to disclose my health information to the persons and entities listed below and any information of other confidential information in the possession of the persons and entities listed below may be disclosed to NLA, my health information includes, without limitation, any record, report, test results, opinions assessments, and any other information relating to medical, emotional, educational or psychological conditions, disclosure may also be made to describe my condition and progress and to discuss treatment.

I understand that I may revoke this authorization a anytime by sending a written notice of revocation to the agency Director at NLA office where I am receiving counseling. I understand that my revocation of this general authorization will not affect a disclosure that NLA has already made under this authorization.

I understand that the information used or disclose under this authorization may be subjected to re-disclosure by the recipient, and may no longer be protected by NLA, Confidentiality rules.

I waive any rights of privacy that I may have in connection with the disclosure hereby authorized.
This authorization is only valid until _____ (fill in date) or until three months after my file is closed at NLA.

Insurance Company	Address	Client Initial
Name	Address	Client Initial
Name	Address	Client Initial
Name	Address	Client Initial
Name	Address	Client Initial

Client Signature _____ Date _____

Name of parents/guardian (if client is under the age of 18) _____ Date _____

Witness _____ Date _____