Patient Name: _____

Date Of Birth: _____ Today's Date: _____

Release/ Request Of Information Authorization Form

By completing and signing this form, I/We authorize A New Dawn Psychotherapy Associates, LLC to release/ request protected information pertaining to my clinical record for the purpose of treatment planning or continued treatment from the contact listed below.

Relationship (Dr, Attorney, Etc)_____
Name of Contact _____
Address _____
City _____ State _____ ZIP _____
Phone _____ FAX_____

*****PLEASE CHECK OFF THE INFORMATION TO BE RELEASED/REQUESTED:**

- ☐ Treatment Plan
- ☐ Discharge Summary
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Complete Medical Record of Any Part Thereof
- ☐ School Records
- ☐ Progress Reports
- ☐ Recommendations
- ☐ Verbal Communication
- ☐ Other_____

I/We understand that in order to protect the confidentiality of my records under HIPAA, I only agree to the release of information form to the party listed above, and will be effective only 1 year from the date signed. I/We also understand that this authorization can be revoked (except to the extent that action has been taken) at any time by dated, written communication to A New Dawn Psychotherapy Associates, LLC. Refusal to sign this form will not impact my treatment.

ONLY VALID FOR ONE YEAR FROM THE DATE IT IS SIGNED

_____
Patient Signature (14 and older) Date

_____
Patient Signature (14 and older) Date

_____
Parent/Guardian Signature (Under 18) Date

_____
Parent/Guardian Signature (Under 18) Date

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