New Hope Center
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Guilford, CT 06437
(Phone) 203-458-2480 • (Fax) 203-458-2479

Release of Information for Records and/or Professional Communication
Please note that this is a legal document and will not be honored unless it is completed in full.

Client's Name:_____ D.O.B.:_____Date:_____

I authorize my therapist at New Hope Center to RECEIVE ☐ RELEASE ☐ the following information regarding myself or my minor child: (Indicate as many as apply, Client or Guardian must initial each section.)

Initials		Initials	
_____	☐ Intake Summary/Assessment	_____	☐ Medication History
_____	☐ Psychiatric Evaluation/Report	_____	☐ Treatment Plan(s)
_____	☐ Alcohol/Drug Use Evaluation Report	_____	☐ Discharge Summary
_____	☐ Educational History/Status	_____	☐ Medical Records
_____	☐ Psychological Evaluation/Testing Report	_____	☐ Progress towards therapy goals
_____	☐ Other (must be specific):_____		

☐ FROM or ☐ TO (agency/individual):_____

Address of Agency/Individual/Hospital/School/Facility:

_____

_____

Pertaining to the period from: _____to:_____

For the purpose of: ☐ Mental health evaluation/or care ☐Treatment planning ☐ Other:_____

----------**Permission for Professional Communication**----------

(Please check only one) This is a: ☐ one-way release of information ☐ two-way release of information

I give permission for the above named individual(s) to communicate verbally or in writing with my therapist at New Hope Center.

This authorization will remain in force until (*choose one*) ☐ 3 months from date signed below
☐ 6 months from date signed below ☐ Other (specify):_____

I understand that I may withdraw this consent at any time prior to the release of the above information and understand that withdrawal of this authorization must be made in writing to my therapist at New Hope Center. I understand that the refusal to grant consent will not jeopardize my right to obtain present or future treatment, except where disclosure of the communications and records is necessary for treatment. This consent, if not withdrawn, will expire after the time period indicated above.

_____ _____
Client's Signature Date

_____ _____
Parent/Guardian's Signature Date

_____ _____
Therapist's Signature Date