NEW HORIZONS LIVING CENTER, INC.

A 501(c)(3) Non-Profit Charity
43 Prospect St. Bristol, CT 06010
Ph. (860) 584-2105 Fax (860) 582-8609
www.nhlcct.org

Authorization for Release of Information

I, _____Of_____,

hereby authorize New Horizon Living Centers to Disclose /Obtain the following information regarding myself

to **Name:** PCP, Probation,Provider:_____

Address: _____ **Phone:** _____ **Fax:** _____

Client/Guardian Please INITIALS the appropriate items:

	Obtain	**Release**
Verbal Release _____	_____	_____ Service/Termination Summary
Written Release _____	_____	_____ Psychological Evaluation
Electronic Release _____	_____	_____Date of admissions Discharge
	_____	_____Diagnosis
	_____	_____Education/School Information
	_____	_____Other (Specify) _____
	_____	

Client Date of Birth_____ **Client SS#** _____

For The Purpose Of Continuum of care. The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes as Well as title 42 of the United States Code. This material should not be transmitted to anyone without the client's written consent or authorization as provided for in these Statutes. I understand that the medical record to be released may contain information pertaining to psychiatric, drug, and/or alcohol abuse diagnosis and treatment, and may also contain confidential HIV (AIDS) related information.

I understand that I may withdraw this consent at any time prior to the release of the above information

This consent if not withdrawn will expire 364 days after the date of signature.

I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the patient and thus may no longer be protected by federal privacy regulations.

I understand that I may inspect or copy the information to be used or disclosed.

_____ _____

Signature of Client/ Date

_____ _____

Signature of Witness Date