A New Dawn, A New Beginning, LLC
850.329.5776 (PHONE)
888.974.6195 (FAX)

CONSENT OR AUTHORIZATION FOR REQUEST OR RELEASE OF PROTECTED HEALTH INFORMATION WITH ANOTHER PROVIDER OR ORGANIZATION

I, _____[Patient/Client], whose Date of Birth is _____,
authorize a New Dawn, A New Beginning, LLC to disclose to and/or obtain the following information:

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Psychotherapy Notes*
_____Other_____
_____Other_____
_____Other_____
_____Other_____

To/From: Please check all that apply

☐ Department of Children and Families
☐ Attorney _____
☐ Probation/Parole _____
☐ Primary Care _____
☐ Other _____
☐ Other _____
☐ Other _____

I understand that Dawna Haswell, LCSW **will request** my protected health information consisting of: demographic and emergency related information, pharmacological history, psychiatric evaluations, medication related info, and previous diagnoses.

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

I understand that Dawna Haswell, LCSW can disclose mental health treatment information and records obtained in the course of psychotherapy treatment of the client, including, but not limited to therapist's diagnosis of client and client attendance.

This consent or authorization for release of information shall be effective the date of signature and **shall expire in one year** from date of signature or at the time services are concluded, if before one year.

I understand that only Dawna Haswell, LCSW can disclose the above-specified information. This authorization is completely voluntary and I do not have to agree to authorize any use or disclosure. I have a right to a copy of this authorization once I have signed it.

I also understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rules, although applicable. Florida Law may protect such information. I acknowledge that I have read, or have had read to me, this authorization and fully understand its contents. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Revocation: I also understand that I may, in writing, revoke this consent or authorization at any time. Revocation has no effect on action previously taken. Revocation will also not prevent me from receiving services at the office of Dawna Haswell, LCSW.

_____ _____
Signature of Client * Date

_____ _____
Signature of Parent/ Guardian (if applicable) Date

**For releasing records relating to a <u>minor</u> between the ages of 12-18, the signatures of both the minor <u>and</u> parent/legal guardian are necessary.*

_____ _____
Signature of Witness Date