A New Day Counseling Center
Western Seminary
5511 SE Hawthorne Blvd.
Portland, OR 97215
Phone: 503-517-1895

☐ Client Request
☐ Counselor Request

Authorization to Release Protected Health Information

I, _____, hereby authorize
Name of Client

_____ of A New Day Counseling Center,
Name of Counselor

5511 SE Hawthorne Blvd, Portland, OR 97215, (786) 263-9329 to mutually share with _____
Name, Title, Business Name, Address, and Phone Number

_____

any and all information pertaining to _____,

for purposes of _____.

I have been informed and fully understand that this protected health information may be in written, oral, or report form.

I fully understand that by signing this form I hereby waive or give up my rights of confidentiality to those above-named and their supervisors. I further understand this communication may include, but not be limited to drug, alcohol, mental health, medical, legal, financial, insurance, or HIV-related information. Unauthorized redisclosure by recipient is a potential risk.

Except as to third party payers, this authorization does not include disclosure for future health care services received more than ninety (90) days from the date of last signature. This release/waiver may be revoked in writing at any time, except to the extent that disclosure has already been made in good faith reliance on this release. I understand that I have the right to refuse to sign this authorization and that my refusal will not condition treatment, payment, enrollment or eligibility for benefits.

Dated this ___ day of _____, _____.

Signed:_____

Signed:_____
(Parent/Guardian)

Date of Birth:_____