New Vision Wilderness
Authorization for Release of Information

Client Name: ___________________________________

This form when completed and signed by you, authorizes NVW to release protected information from your clinical record to the persons you designate.

I authorize New Vision Wilderness staff to release or obtain information with the following agencies or persons.

Name of agency: ____
Name of contact person: ____
Address: ____
____
Phone:____

Name of agency: ____
Name of primary therapist: _______________________________________
Address:____
____
Phone:____

Name of agency: ____
Name of secondary therapist: _______________________________________
Address: ____
____
Phone:____

Name of school: ____
Name of contact person: ____
Address:____
____
Phone:____

Name of agency: ____
Name of additional professional: _____________________________________
Address:____
____
Phone:____

Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.
____
____

I am allowing New Vision Wilderness to release or obtain this information for the following reasons: ("at the request of the individual" is all that is required if you do not desire to state a specific purpose.)
____
____

This authorization shall remain in effect until _____________ (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).
____
____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the New Vision Wilderness office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that New Vision Wilderness generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

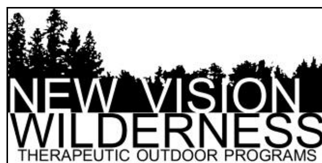
____ ____________________

Signature of Client Date

____ ____________________

Signature of Legal Guardian Date

(If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must be provided.)



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