New Directions Counseling Corp.
1200 Airport Heights Drive Suite 170
Anchorage, Alaska 99508
Phone (907) 929-5258
Fax: (907) 929-5256

Authorization for release of information

I (We) authorize New Directions Counseling Corp to release and disclose information from the clinical record of the named person below:

______________________________ ______________
Name of client/recipient of mental health services Date of Birth

to, and allow such information to be inspected and copied by:

____
Facility/Provider

____
Address

____
State the specific nature of information to be disclosed

____
State the specific purpose of information to be disclosed

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to New Directions Counseling Corp. I understand that a revocation is not valid to the extent that New Directions Counseling Corp has acted in reliance on such authorization. This authorization is valid until the date that is stated below:

Effective date: _______________

A copy of this release shall have the same force and effect as the original.

______________________________ ______________________________
Client Signature (12 yrs. or older) Date Parent/Guardian Signature Date

______________________________ ______________________________
Witness Date Relationship to Client Named

NOTICE TO RECEIVING FACILITY/THERAPIST:

1. You may not disclose any of this information, unless, the person who consented to this disclosure specifically consents to such disclosure.
2. I understand that there may be potential for re-disclosure of this information by the recipient. If this does occur, this information may not be protected by federal law.