New Directions Counseling Corp.

1200 Airport Heights Suite 170
Anchorage, AK 99508
Phone (907) 929-5258

Authorization for release of information

PLEASE PRINT

I (We) authorize the person(s) or agency named below to release information that is listed below to **New Directions Counseling Corp**, for the purposes of facilitating counseling/consultation, and/or conducting an evaluation.

_____
Facility/Provider

_____
Address

_____
State the specific nature of information to be disclosed

This information is from the clinical record for the respective client/recipient that is listed below:

_____ _____
Name of client/recipient of mental health services Date of birth

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.