



Authorization for Use or Disclosure of Protected Health Information

Client Name: _____ **Date of Birth:** _____
(Please print)

I authorize New Leaf Resources to use or disclose my protected health information as described below.
Specific information I authorize to be used or disclosed is:
(Please specify, including dates of treatment and/or names of providers when appropriate)

Organization/s or Person/s New Leaf Resources is authorized to release my information to:

Purpose/s of the use or disclosure:

_____ at the request of the individual

_____ other (please specify) _____

Consequences of my refusal to sign this authorization (**Required**): _____

I understand the following:

- Any information used or disclosed because I have signed this authorization may no longer be protected by privacy laws and may be subject to re-disclosure by the person or organization receiving it.
- I have the right to revoke this authorization at any time by doing so in writing and presenting my written revocation to New Leaf Resources.
- Any request to revoke this authorization will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Any request to revoke this authorization will not apply to the extent New Leaf Resources has taken action in reliance upon my authorization.
- I may refuse to sign this authorization and New Leaf Resources will not condition treatment based upon my providing a signature on this authorization unless it is for research related treatment or provision of care for the sole purpose of creating information for a third party. If I refuse to sign in either of these two instances, I understand you may refuse to treat me.
- I may inspect or copy any information to be used or disclosed based upon this authorization.

Client's or Legal Representative's Initials _____

This authorization expires on _____, 20____, or upon the event of _____.

If no date or event is stated above, this authorization is effective only on the date it is signed for mental health records.

Signature of Client or Legal Representative

Date

Legal Representative's Printed Name and Relationship to Client

Witness Printed Name and Signature (**Required**)

Date

Important Notice: Any information protected by Federal Regulations governing substance abuse treatment (42 CFR, Part 2) or the Illinois Mental Health and Developmental Disabilities Confidentiality Act is prohibited from further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.