NURTURING LIFE CONCEPTS, LLC
AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name _________________________________ Client Date of Birth _________________

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan, health care provider or clearing house, the released information may no longer be protected by federal privacy regulations, except that a recipient may be prohibited from redisclosing substance abuse information under the federal substance abuse confidentiality requirements. State law governs the release of HIV/AIDS information and you may request a list of persons authorized to re-release HIV/AIDS related information.

Persons/organizations providing/receiving the information:

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Persons/organizations providing/receiving the information:

Wendy A. West Pidkaminy, LCSW-R
Nurturing Life Concepts, LLC

Describe information to be released (medical exams, medical evaluations, alcohol evaluations, drug evaluations, psychiatric evaluations, social worker assessments, patient history, presenting diagnosis, educational information and records, social and relational functioning, prognosis, treatment recommendations, collateral contacts, observations and opinions): (Circle appropriate responses or state all pertinent information deemed essential to allow any and all information to be shared) other:____
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Dates of requested information: From _____________________ To ________________________
I consent to the release of any HIV/AIDS information ***unless the box*** is checked.
❒ Do not disclose HIV/AIDS information

2. Purpose of the use/disclosure **Counseling, Parent/Life Coaching, Spiritual/Pastoral Care NHA Consultation or Training**.
3. I understand the provision of health care to me will not be affected if I do not sign this form, but payment may be effected.
4. I understand that I may see and copy the information described on this form if I ask for it, and that I may request a copy of this form after I sign it.
5. I may revoke this authorization at any time by notifying the Nurturing Life Concepts, LLC privacy officer in writing, but if I do it will not have any affect on any actions they took before they received the revocation. This authorization will expire on __________________________________.

____
Signature of client, parent or legal representative / Witness Date

Printed name, address, and phone of individual, parent, or legal representative_____________________________
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Relationship to the individual____

HIV/AIDS specific information:

For questions/complaints regarding HIV/AIDS discrimination, call the New York State Division of Human Rights at (518) 474-2705 or the New York City Commission on Human Rights at (212) 306-7450.

Federally protected substance abuse information:

I understand that my records are protected under the federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Questions may be addressed to Nurturing Life Concepts, (315) 682-4005, 8195 Cazenovia Road Suite 9 Manlius, New York 13104