NEW BEGINNINGS COUNSELING & CONSULTING LLC

20 Peddlers Village
Newark, DE 19702
(302) 545-7085 Fax: (302) 307-8698

RELEASE OF INFORMATION TO PRIMARY CARE PHYSICIAN (PCP)

I understand that my records are protected under Federal Regulation 42CFR and under the general laws of my state, and cannot be released without written consent, except as specifically stated by law.

I understand that, under federal law, the provider named below may release information from my records, without my consent, when:

A. There is an indication of child abuse or abuse of disabled adults.
B. Given the best clinical judgment, there is threat to safety to self or others (suicidal or homicidal).
C. Required to present records to comply with a court order.

This authorization expires one year from today's date or the date services terminate. I understand that I may revoke my authorization to release information at any time in writing, and such revocation will be effective on the date of receipt of my revocation.

I, _____, residing at, _____
Name Address

_____, hereby give my informed **consent** for

_____ to talk with and/or release written documentation,
Name of Provider

regarding my treatment to _____.
Name of PCP

_____ _____
Signature of Client Signature of Parent or Guardian

_____
Date

*******OR*******

I, _____, **do not consent** to information being released to
Name

Primary Care Physician.

_____ _____
Signature of Client Signature of Parent or Guardian

_____
Date