A New Outlook Recovery Services & Colorado TMS

Office #: (303) 798-2196 Fax #:(303) 730-2418 1510 W. Canal Ct. Ste 2500 Littleton, CO 80120

I, _____ hereby authorize:

Client Name and Date of Birth

Agency or Individual	**Address**	**Phone or Fax #**

To release the following health information about me, TO: A New Outlook Recovery Services/Colorado TMS: (Please check appropriate boxes)

No	Yes	
		Name and/or phone number
		Demographic information (age, sex, ethnicity, address, etc.)
		Diagnosis(es)
		History and/or Physical
		Laboratory results: _____
		Psychological/Psychiatric evaluation summary: _____
		Billing/Financial information
		Progress Report/Treatment Summary/Family Therapy Summary
		Urinalysis/Breathalyzer results record
		Other (Specify): _____

**Information contained psychotherapy notes may not be released by this authorization. A special authorization must be obtained.

The information is required for: (Please check boxes that apply, if "Other" is checked, you *MUST* describe the purpose forinformation being provided.

	Treatment (to obtain additional)		Court for:_____
	Consideration/Maintenance of Employment		School, eligibility, credits
	Probation/Parole, ongoing eligibility		Voc Rehab, initial and ongoing eligibility
	Social Services, to obtain eligibility for treatment		Family members, to inform them of my care and treatment
	Other: (Specify):_____		

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Part 160 &164, and cannot be disclosed without my written permission unless otherwise provided for by the regulations I also understand that I may revoke this permission in writing at any time (refer to your copy of the HIPAA Notice of Privacy Practices for information on how to revoke this permission) except to the extent that action has been taken in reliance on it, and that in any event this permission expires automatically on the date written below:

_____

Date (2 Years)

I understand that generally, A New Outlook Recovery Services., may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances, I may be denied treatment if I do not sign an authorization form. For example, if funding for my treatment is contingent on the agency providing the funding receiving reports on my progress in treatment, I may be refused treatment funded by that source if I am unwilling to consent to release progress reports. I also understand that the people who get this information may give out my information, and it may no longer be protected. However, A New Outlook Recovery Services, will try to prevent redisclosure of my information by providing notification of prohibition of redisclosure to those receiving my information. I understand that I will be given a copy of this permission once I have signed and dated it.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Authorized Representative (Describe relationship) Date

_____ _____

Witness Date

(Send original if requesting information from another party. Send copy if releasing information to another party. Send copy ifinformation requested from A New Outlook Recovery Services, LLC., by another party.) *01/2011*