



NEW PATH PSYCHIATRY

1420 W Canal CT, Ste 20

Littleton CO, 80120

Tel: 720-466-1932

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office@newpathpsychiatryco.com

www.newpathpsychiatryco.com

OPTIONAL RELEASE OF MENTAL HEALTH INFORMATION

(If you do not agree to this release, please leave this page blank and do not sign below)

Client Name: _____ Date of Birth: _____

I authorize that information may be exchanged between the following third-party(ies) and New Path PLLC, dba New Path Psychology ("New Path"):

Name: _____ Relationship to Client: _____
Address: _____ Phone: _____
FAX: _____

Name: _____ Relationship to Client: _____
Address: _____ Phone: _____
FAX: _____

I authorize the disclosure of the following information:

_____ All Information _____ Diagnosis _____ Clinical Progress Notes
_____ Psychological Evaluation _____ Intake Information _____ Discharge Summary

This information and these records may contain information concerning HIV testing or AIDS diagnosis or treatment.

- I consent - I do not consent to have information on HIV testing or AIDS released.

This information and these records may contain information concerning substance abuse diagnosis or treatment.

- I consent - I do not consent to have information on substance abuse diagnosis or treatment released.

I understand that depending on my election above, information disclosed pursuant to this authorization may include information relating to sexually transmitted disease, HIV/AIDS, treatment for alcohol and drug abuse, and psychological or psychiatric conditions, unless later restricted as detailed below. Once information is disclosed pursuant to this signed authorization, I understand that general federal privacy laws designed to protect confidential or private information, including HIPAA, may not apply to the recipient of the information, and therefore, those regulations may not prohibit the recipient from re-disclosing the information.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. In order to revoke this authorization with respect to information other than drug and alcohol treatment program records, I understand that I must provide written notice by reasonable means to



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New Path. If not revoked earlier, this release and authorization will expire one year from the most recent date signed. I release New Path and all of the above parties from any and all liability that could result from disclosing information subject to this release. I further acknowledge a copy of this release and authorization may be utilized with the same effectiveness as an original.

I understand that I may refuse to sign this authorization, and this will not affect my ability to receive treatment at New Path. New Path does not recommend email as a means of communication. There are some risks that any protected health information that may be contained in such email may be disclosed to, or intercepted, unauthorized third parties. By signing this form I acknowledge that email is not secure and I am releasing New Path from any liability relating to unauthorized disclosure of information contained in email correspondence.

Signature of client or authorized representative

Date

(print name)

(print client name and authority to act, if applicable)