a new dawn
family solutions

Authorization for Release/Exchange of Information

Client Name:			☐**Male** ☐**Female**
Date of Birth:		**Social Security Number:**	
Address:			
Phone:		**Alt. Phone:**	

I, _____ (Client/Parent or Legal Guardian), consent to the release of the following information between:

☐Rana Dimmig, MSS, MLSP, LSW and/or ☐Thomas Givler, BS
A New Dawn Family Solutions, LLC
46 South Chestnut Street, Boyertown, PA 19512
610-427-0619/484-577-1394

And:

Name of Person/Agency:			
Address:			
Phone:		**Alt. Phone:**	

This consent will cover ☐ written, ☐ verbal, ☐ electronic communication regarding:

☐Treatment Progress
☐Assessment
☐Recommendations
☐Discharge.
☐Medical Information
☐Billing & Payment
☐Diagnosis
☐Psychological Evaluation
☐Drug and Alcohol Treatment Records
☐Other:_____

This release shall be valid for one year from the date of my signature or until withdrawn in writing. I understand that if I decide to revoke this consent in writing, it will prevent any disclosures after the date it is received, but cannot change the fact that some information may have been sent or shared before that date. I understand I have the right to refuse to sign this form. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

_____ _____
Client (if over 14, parent or guardian if under 14) Date

_____ _____
Witness to signature Date