7777 Glades Road Suite 205
Boca Raton, FL 33434
(561) 613-5217

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

Name:_____ **Date of Birth:** ____/____/____

This will authorize **New Vu Therapy, LLC** to disclose and/or obtain information from the following:

_____

The following information: (**Check and initial** each item to be included)
[ ] Assessments _____
[ ] Evaluations _____
[ ] Treatment Plan/Summary _____
[ ] Treatment Progress _____
[ ] Discharge/Transfer Summary_____
[ ] Medical Information _____
[ ] Educational Information _____
[ ] Other (please specify) _____

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, and coordinate treatment services amongst providers. Please specify any other purpose: _____

Right to Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to New Vu Therapy, LLC at the address listed above. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
[ ] This information release is for a specific instance, valid for 90 days, and expires on the following date _____.
[ ] Unless sooner revoked, this consent is valid for 1 year due to the need for ongoing communication for the coordination of treatment expires on the following date _____.

Conditions
I understand that New Vu Therapy, LLC, will not condition my treatment on whether or not I give authorization for the requested disclosure.

Form of Disclosure
Unless you have requested in writing that disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner deemed to be appropriate and consistent with applicable law, including but not limited to verbally, on paper or electronically.

Re-disclosure
Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

Client _____ Date _____

Parent/Guardian _____ Date _____

Witness _____ Date _____