Welcome to New Life Resources, Inc.

In order to serve you effectively, we request you to provide the following information. Thank you.

1. Name, address, and phone number of your physician: ____

   ____

   ____

   Communication between behavioral health providers and your primary care physician (PCP), other health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. On the back of this page is a consent form which will allow your behavioral health provider to share protected health information (PHI) with your other health care physician(s). This information will not be released without your signed authorization. This may include diagnosis, treatment plan, progress, and medication, if necessary.

2. Medical concerns, surgeries, chronic illnesses: ____

   ____

   ____

3. Medications, vitamins, herbs, and/or other treatments you are currently using: _____________

   ____

   ____

4. Prior and current mental health, counseling, and psychiatric treatments: (please include approximate dates)

   ____

   ____

5. Names, ages, and relationship of those who live with you: _______________________________

   ____

   ____

6. Any other information you would like to provide at this time: ____________________________

   ____

   ____

CONSENT FOR COORDINATION OF CARE BETWEEN HEALTH CARE PROVIDERS

Patient Rights

- You may terminate this authorization any time by contacting your provider's/therapist's office.
- If you make a request to cease this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- If you choose not to agree with this request, your benefits or services will not be affected.
- You have a right to a copy of this signed authorization.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. **This consent expires in twelve (12) months from the date of my signature below unless otherwise stated herein.**

The NLR provider listed below is authorized to release/obtain protected health information related to the evaluation and treatment of

____ ______ /______ / _________.

(Name) (Date of birth: MM/DD/YYYY)

Physician's Name: ____ Phone: ______________________________

Address: ____

2nd Physician's Name: ____ Phone: ______________________________

Address: ____

NLR Provider/Therapist Name: ____

New Life Resources, Inc. 20700 Watertown Road, Suite 102 Waukesha, WI 53186
Phone: 262-782-1474 Fax: 262-782-1441

Disclosure may include the following verbal or written information (provider to fill out, check all that apply):

_____ Face sheet _____ History & Physical _____ Laboratory/diagnostic testing results _____ School information
_____ Discharge summary _____ Medication records _____ Behavioral health/psychological consult _____ Psychological eval/testing results
_____ ER record report _____ Psychiatric evaluation _____ Psychosocial assessment _____ Other
_____ Substance abuse treatment record _____ Summary of treatment records & contact dates

_____ I hereby **refuse** to give authorization for any release of information. (Check if choosing **not** to allow communication between therapist and health care providers)

____ ______________________________

Signature of patient, parent, guardian, or authorized representative Date