# A New Tomorrow
# Behavioral Health Services

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## RELEASE OF INFORMATION & CONSENT FORM

**CLIENT NAME:_____ DOB:_____**

**SSN:_____ PHONE: _____**

**ADDRESS:_____CITY, STATE, ZIP _____**

I, _____, hereby authorize the release and exchange of information specified below between:

_____

Name/Title or Organization Name

_____

Organization/Address

_____

Phone Fax

And: A New Tomorrow
444-B Broad St.
Sumter, S.C. 29150-4157

This release of information shall be limited to the following specific types of information:

**____Assessment**
**____Diagnosis**
**____Psychosocial Evaluation**
**____Psychological Evaluation**
**____Psychiatric Evaluation**
**____Treatment Plan or Summary**
**____Current Treatment Update**
**____Medication Management Information**
**____Presence/Participation in Treatment**
**____Nursing/Medical Information**
**____Toxicological Reports/Drug Screen**
**____Educational Information**
**____Discharge/Transfer Summary**
**____Continuing Care Plan**
**____Progress in Treatment/Notes**
**____Demographic Information**
**____Other_____**
**____Other_____**

_____

**CLIENT NAME (PRINTED)**

_____

**CLIENT SIGNATURE/GUARDIAN** **DATE**