

## RELEASE OF INFORMATION

Name of Participant: \_\_\_\_\_

I hereby request and authorize:

**NEW FOUNDATIONS, 826 HARRIS AVE CINCINNATI OH 45205**

(513) 813-2787 office; (513) 440-1760 fax

To disclose or obtain information from:

\_\_\_\_\_

Name of Person or Agency Holding or Requesting Information

\_\_\_\_\_

Address

The following type(s) of information from my records (and any specific portion thereof):

\_\_\_\_\_ Information Contained in Notes/History

\_\_\_\_\_ Alcohol and Drug Test Results

\_\_\_\_\_ Intake and Exit Information

\_\_\_\_\_ Transaction History

\_\_\_\_\_ Other \_\_\_\_\_ for the purpose of \_\_\_\_\_

All information I hereby authorize to be obtain from this agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for:

\_\_\_\_\_ Ninety (90) days unless I specify an earlier expiration date here: \_\_\_\_\_

\_\_\_\_\_ One (1) year

The period necessary to complete all transactions on account related to services provided to me.

**I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.**

\_\_\_\_\_

Date

\_\_\_\_\_

Participant Signature

\_\_\_\_\_

Witness/Title Signature

\_\_\_\_\_

---

Use This Space Only if Participant Withdraws Consent

\_\_\_\_\_

Signature of Witness/Title

\_\_\_\_\_

Signature of Participant