NEW FOUNDATIONS
RECOVERY HOUSING Heal. grow. Live.

**New Foundations Recovery Housing**

**(513) 813-2787 office**
**(513) 586-0455 fax**

# Authorization for Release of Information

**Name of Participant:**_____

**I hereby request and authorize:**

**New Foundations Recovery Housing**
**167 E. McMillan St.**
**Cincinnati, Ohio 45219**
**P: 513-813-2787 F: 513-586-0455**

**To disclose or obtain information from:**

_____

**Name of Person or Agency Holding Information**

_____

**Address**

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

_____**History and Physical**
_____**Alcohol and Drug Abuse Treatment Records**
_____**Laboratory Reports**
_____**Psychological Reports**
_____**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** **New Foundations House Leader/Staff Signature**

**Use This Space Only if Resident Withdraws Consent**

_____ _____

**Signature of Witness/Title** **Signature of Resident**