**NWEC Authorization for Release of Information (Research)**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization will remain in effect for 90-days after the completion or termination of my treatment by NWEC.

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization allows for the information and data from the participant's individual file to be used for research and evaluation. Any information that is disclosed for research/evaluation will remain confidential.

I have read and understand my rights as a client regarding my personal health information. This release is optional. I may choose to deny access to research with no negative consequences for doing so.

**Signature of Client**

**I consent to allow my data/information to be used for confidential research and evaluation purposes**

**I decline to allow my data/information to be used for confidential research and evaluation purposes**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Date