counseling associates

Authorization to Disclose Health Information

I, _____, born on this date _____
(Name of person whose information is being disclosed)

authorize **Counseling Associates of New London, PLLC** to

☐ Release ☐ Receive ☐ Exchange

Protected Health Information (PHI) about the above referenced individual to:
(Doctor, Family Member, School, etc... You are allowing information to be released to/from the following person.)

Name:	Phone:
Address:	

Information as described below:

Category of Protected Health Information: I authorize the disclosure of information from the following categories of protected health information (check those that are applicable):

☐ Mental Health (MH) ☐ Substance Use Disorder (SUD) ☐ Both (MH/SUD)

Type of Information / Record: Check the information / record type you wish disclosed

Check ☐**Yes** if you request the **Entire Record** to be disclosed - *this includes, but is not limited to: assessment, treatment plans, progress notes, medication, attendance, test results, behavioral support plans, discharge reports, etc.*

Check ☐**No** if you wish to specify which of the items below to disclose:

☐Yes	☐No	Attendance
☐Yes	☐No	Assessments/Evaluations including diagnosis, treatment recommendations
☐Yes	☐No	Treatment Plan/Individual Plan of Care
☐Yes	☐No	Progress Notes
☐Yes	☐No	Medications Prescribed
☐Yes	☐No	Agency Discharge Summary/Plan
☐Yes	☐No	Behavioral Support Plans
☐Yes	☐No	Test Results (includes lab results and urine toxicology reports)
☐Yes	☐No	HIV/AIDS
☐Yes	☐No	Other (must specify):

Date range of information to be disclosed:

The purpose of the disclosure:

Date or event upon which this authorization will expire:

I understand that if I do not note a date or event, this authorization will expire one year from the date signed below.

If none is indicated the means of this disclosure may be written, verbal, or electronic.

• I understand that my substance use disorder treatment records are protected under federal regulations, 42 CFR Part 2, and cannot be discloed without my written consent, unless otherwise allowed by the regulations or required by law.

• I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, protect all of my healthcare records and may only be disclosed as permitted by the regulations or with my authorization.

• For disclosures of information made to organizations outside of the State of New Hampshire, health information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy Standard of HIPAA.

• I understand that confidentiality of such records is also protected by State law.

• I understand that generally Counseling Associates may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied participation in the services if I do not sign an authorization form.

• I understand that I may be denied services if I refuse to consent to a disclosure for purposes of treatment payment or healthcare operations.

• I also understand I will not be denied services if I refuse to authorize a disclosure for other purposes.

• I understand that I may request restrictions on the use or disclosure of information for the purposes of treatment, payment, and healthcare operations that Counseling Associates may or may not agree to the requested restrictions.

• I understand I may revoke this authorization at any time except to the extent that the practice or other agency making the disclosure has already acted in reliance on it. In general, revocation should be submitted in writing and sent to the practice at our address.

I have read all of the above information and I understand its content and authorize the disclosure of confidential information identified above to the party listed above.

Name of Client (please print) _____ Date _____

Signature of Client _____ Date _____

Signature of Parent/Guardian _____ Date _____