Counseling Associates

(603) 865-1321
fax: (603) 865-1327
ca-mh.com

Authorization for Release of Protected Health Information

➔ Name: _____ DOB: _____

I hereby authorize Counseling Associates of New London, of Newport, of Claremont & of The Upper Valley to:

➔ ☐ Release ☐ Receive ☐ Exchange Protected Health Information about me to:

➔ (Name and address of individual or entity to whom this information may be disclosed.)

Name: _____ Telephone: _____

Address: _____

☐ Medical Provider ☐ School ☐ Attorney ☐ Family/Friend **or** ☐ Other: _____

Please check one. Purpose of disclosure:
☐ Coordination of services ☐ Medical/Mental Health Record ☐ Billing Information **or** ☐ Other: _____

Please check one. Authorized Means of Disclosure:
☐ Disclosure includes Fax, Written and Verbal **or** ☐ Disclosure is limited to: ☐ Fax ☐ Written **or** ☐ Verbal

Please check one. Dates to be released:
☐ All dates of service **or** ☐ Specify time period from which information is to be released: From _____ to _____

Please check one:
☐ Date or event upon which this authorization will expire: _____ **or**
☐ I understand if I do not note a date or event, then this authorization will expire one year from the date it was signed below.

Please check:
☐ I understand that in authorizing release of information from Counseling Associates, I am authorizing release of Mental Health Records or records related (e.g. billing information). Additionally, to the extent my record contains information about any of the following, I hereby expressly grant authorization to release such information:
Please initial: HIV test results _____ Genetic Testing_____ **or** Substance abuse records (prognosis, diagnosis, or treatment records of patient for drug or alcohol abuse protected by Federal confidentiality rules (42 CFR part2)) _____

- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.
- I understand that I may revoke this authorization in writing at any time by notifying Counseling Associates except to the extent that action has been taken in reliance on this authorization prior to the revocation date, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Revocation will be effective as of the date received.
- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by Federal or State privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

_____ _____
Signature of Client/ Parent/ Legal Guardian Date

_____ _____
Printed name of personal representative Legal authority of personal representative

_____ _____
Witness Date

35 Newport Road
New London, NH 03257

Newport Health Center
11 John Stark Highway
Newport, NH 03773

251 Elm Street
Claremont, NH 03743

2 Buck Road
Hanover, NH 03755