MERRIMACK VALLEY COUNSELING ASSOCIATION

39 Simon St. #2A, Nashua, NH 03060 * Tel. (603) 888-4347 * Fax (603) 577-9157

RELEASE OF INFORMATION AUTHORIZATION

CLIENT/PATIENT NAME: _____ DOB: _____

I authorize _____ to ☐ disclose and/or ☐ receive protected health information for the following purpose:

☐ Transferred Care ☐ Insurance ☐ Personal Records ☐ Workers' Comp ☐ Attorney

☐ Further Care ☐ Current Treatment Information ☐ Other (specify)_____

Please check one:

☐ Send/disclose information **TO** *or* ☐ Receive information **FROM**

Name: _____

Address: _____

Phone and Fax # _____

E-mail address: _____

Type of Information requested:

☐ Discharge Summary
☐ Treatment Plan(s)
☐ History & Physical
☐ Assessments/Evaluations
☐ Consultation
☐ Emergency Dept. Record
☐ Medications
☐ Laboratory Data
☐ EKG
☐ Physician/NP Orders
☐ Progress Notes
☐ Nurses Notes
☐ Medical History
☐ Social History
☐ Court Orders
☐ Legal History
☐ School Records
☐ Verbal/telephone exchange of information
☐ Telephone/fax Communication
☐ Third party Information
☐ Summary of Client Notes Verbal/written

☐ Other (specify) _____

Dates of care to be released: _____

I UNDERSTAND THAT: I authorize the following information to be disclosed by initialing:

Drug and/or alcohol abuse treatment: Initials: _____ **HIV(AIDS) testing/treatment: Initials: _____**

Psychiatric: Initials: _____ **Sexually transmitted disease: Initials: _____**

Confidential details of:

Psychotherapy: **Initials: _____** Domestic Violence/Victims' Counseling: **Initials: _____**

Social Work Counseling/Therapy: **Initials: _____** Sexual Assault Counseling: **Initials: _____**

- I can revoke this authorization at any time by submitting a request in writing
- This will not apply to any previously released information. I understand that this will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- This authorization will automatically expire from this date or event (please check one):

☐ 6 months ☐ 1 year ☐ Upon termination of treatment with the Merrimack Valley Counseling Association provider named above

I have carefully read and understand the above, have had any questions explained to my satisfaction, and expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons and agencies listed above. **The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.**

Client/Patient Signature: _____ Date: _____

Print Name: _____

If a minor, signature of legal representative: _____ Date: _____

Print Name:_____ Relationship to Client/Patient: _____