Exeter Counseling Center, PLLC
163 Water St., Exeter, NH 03833
603-778-7433

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Client's Name: _____
Last First MI

Birthdate: _____ Phone #: _____

I, the undersigned, hereby voluntarily authorize that the HIPAA Protected Health Information noted below be released from my medical, school, and/or mental health record. I request Exeter Counseling Center to

☐ release to ☐ obtain from

Name:_____

Address:_____

Telephone: _____ FAX: _____

the following information:

☐ clinical notes ☐ school records ☐ psychological testing/evaluations

☐ phone contact ☐ other - please specify_____

Under federal regulation 42CFR, specific types of information are protected and I have the right to refuse release of this information. Initialing any of the items below indicates that I consent to the release of this specific information:

___ Alcohol and/or Drug Treatment

___ HIV-related Information

☐ This release is for the purpose of facilitating evaluation, treatment planning and/or coordination my care.

☐ This release is specifically for a legal matter: _____

This authorization will remain in effect for one year. I understand that I may revoke this authorization, in writing, at any time, except to the extent of action already taken on my original consent to release protected information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

_____ Date: _____
Signature of Client (or parent, if a minor)

_____
Witness