MERRIMACK VALLEY COUNSELING ASSOCIATION

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

20 Merrit Parkway, 2nd Floor, Nashua, NH 03062
Tel. (603) 402-9365 Fax (603) 402-9389

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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 # ____

Type of Information requested:

☐ Discharge Summary
☐ Treatment Plan(s)
☐ History & Physical
☐ Assessments/Evaluations
☐ Consultation

☐ Emergency Department 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

☐ 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.

Client/Patient Signature: ____ Date: ______________

Print Name: ____

If a minor, signature of legal representative: __________________________________ Date: __________________

Print Name:___________________________________ Relationship to Client/Patient: __________________________