The Mental Health Center of Greater Manchester AUTHORIZATION TO RELEASE INFORMATION

NAME: _____ **SS#:** _____ **DOB:** _____ **Case #:** _____

I, the undersigned, understand that consent for release of information is not a required condition for treatment and I hereby voluntarily authorize that Protected Health Information (including psychiatric) be:

☐ **PROVIDED TO: AND/OR** ☐ **OBTAINED FROM:**

_____ _____
Name of Agency/Person **Telephone Number**

_____ _____
Street Address (where records are to be sent) **Fax Number**

_____
City / State / Zip Code

FEES: There may be a charge for copying records. Please be as specific as possible about the information you are requesting, as well as the treatment date range.

SELECT ONLY ONE: REQUIRED

☐ This release covers all treatment dates up to the date signed below, **OR**

☐ This release covers all treatment dates and continues through my current episode of care, **OR**

☐ This release only covers treatment dates ___/_____/____ through ____/_____/_____

(Check the items that you wish to have released) REQUIRED

☐ Assessments ☐ Treatment Plans/Reviews ☐ Progress Notes ☐ Summaries ☐ Insurance/Billing
☐ Physician Orders (NOTE: Your medication history may include dates outside the "treatment dates" specified above.
☐ Other (type of information being requested) _____
☐ Research Records **- include all items protected under a Certificate of Confidentiality ☐ Yes ☐ No**

The following requires a separate authorization and may not be combined with any other checked items.
If The Mental Health Center of Greater Manchester is to RECEIVE psychotherapy notes (as defined in the HIPAA Privacy Rules), check here ☐ **Psychotherapy notes may be released to The Mental Health Center.**

_____

☐ Yes ☐ No I specifically authorize disclosure of information concerning my alcohol or drug abuse treatment. I understand that all related information is protected under Federal Regulation 42 CFR and that I have the right to refuse release.
☐ Yes ☐ No I specifically authorize disclosure of information concerning my HIV/AIDS status. I understand that I have the right to refuse release.

The purpose of the release is for: (REQUIRED)
☐ Treatment Planning ☐ Evaluation ☐ Discharge/Aftercare Planning
☐ Legal Matter (specify): _____ ☐ Other: _____

UNLESS OTHERWISE INDICATED, THIS RELEASE AUTHORIZES THE SHARING OF INFORMATION VERBALLY, WRITTEN AND ELECTRONICALLY.

☐ **I am requesting MHCGM send written/electronic information to the above agency/person as soon as possible upon receipt of this request.**

☐ **I am requesting MHCGM obtain written/electronic information from the above agency/person as soon as possible upon receipt of this request.**

I understand that I have a right, upon request, to a list of entities to which my information has been disclosed pursuant to the general designation. I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it. The information used or disclosed may be subject to re-disclosure by the recipient and no longer be protected by the Privacy Regulations. Federal rules 42CFR Part 2 prohibits further disclosure of SUD information unless expressly permitted by written consent and restricts any use of information to investigate or prosecute with regards to a crime any patient with a substance use disorder, except in connections with a crime committed on the premises or against a SUD provider, or consistent with 42 CFR Part 2 section 2.65.

This release expires six months following my discharge from The Mental Health Center unless a shorter period is specified here: _____.

For persons whose case is closed at the time this release is completed, the release will expire in 6 months unless a shorter period is specified here: _____.

_____ _____ _____
Signature of Client/Former Client Date ☐ Signature Parent/Legally Authorized Representative Date

Medical Records
The Mental Health Center of Greater Manchester
1555 Elm St.
Manchester, NH 03101
Fax – 603-518-5463 P – 603-668-4111 ext. 4181

_____
Printed Name of person signing

_____
Describe Authority of Representative