GNMH Greater Nashua Mental Health

Release of Information

AUTHORIZATION TO RELEASE / RECEIVE INFORMATION

Please Send Records ☐	File Only ☐

All areas must be completed and form signed prior to providing or obtaining information

Client Name: _____ **DOB:**_____

Authorize Greater Nashua Mental Health Center to:

☐ PROVIDE INFORMATION TO **OR** ☐ REQUEST INFORMATION FROM

The person, company or agency named below:

*(Please note, if the information being released is protected by 42 CFR Part 2, **the specific recipient must be identified below**)*

Name:	**Relation to client:**
Address:	
Phone:	**Fax:**

Purpose of this Disclosure

☐ **Coordination of Care**	☐ **Involving Family/ Spouse**	☐ **Legal Matter**	☐ **Other:**

SELECT ONLY ONE:

☐ This Release covers all treatment dates and continues through my current episode of care or expiration date, **OR**

☐ Release information for treatment dates from: ____/____/_____ to ____/____/_____

The patient or the patients legal representative is requesting the following documents be released:

☐ **Initial Assessment Evaluation**	☐ **Treatment Plan**	☐ **Lab Reports**
☐ **Psychiatric Assessment**	☐ **Clinical Notes**	☐ **Telephone / Verbal Communication**
☐ **Discharge Summaries**	☐ **Medication List**	☐ **School Records (IEP, 504 Plan)**
☐ **Other:**		

Client records may contain information relating to drug and or alcohol treatment that is protected by Federal confidentiality regulations (42 CFR Part 2). Federal regulations prohibit any future disclosures without the specific written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general release of medical or other information is NOT sufficient for this purpose.

Your **INITIALS** are required to release the following:	_____**Mental Health**	_____**Drug/ Alcohol**	_____ **HIV/ AIDS**

- *I understand that I need not consent to the disclosure of information in order to obtain treatment services.*
- *I choose to disclose this information willingly and voluntarily for the purpose specified above.*
- *Unless otherwise indicated, this release authorizes the sharing of information verbally, written and where available electronically, including through NH Health Information Organization (NHHIO).*
- *I hereby authorize Greater Nashua Mental Health Center to use/disclose my individually identifiable information (which may include HIV/AIDS status or genetic testing, if applicable)*
- *There is potential for information disclosed under the terms of this authorization to be redisclosed by the recipient and no longer protected by 45 CFR Part 164, Subpart E Privacy Rule.*
- *I may revoke this authorization at any time by submitting a request in writing to: Greater Nashua Mental Health Center's Medical Records Department at 100 West Pearl Street, Nashua NH 03060. This request will not apply to any previously released information.*
- *Unless revoked or a specific date is indicated below, this authorization will expire one year from date of signature.*
  - ☐ Other date of expiration (if less than one year): _____
- *When providing couples, family or marital treatment, we will not disclose information to others involved in the treatment or any external party without prior written authorization from each individual participant of legal age to consent and/or their parent or legal guardian. A family member, spouse or any other individual who participates in an individual therapy, on occasion, would not classify that treatment as couples, family or marital therapy unless specifically identified as such in the medical record.*
- *My signature below indicates that I have both read and understand the information described above.*

Client/ Parent/ Legal Guardian Signature:_____ **Date:**_____

Witness Signature:_____ **Date:**_____