WILLOWDALE COUNSELING CENTER, PLLC

NASHUA
76 Northeastern Blvd, Unit 36A
Nashua, NH 03062

603-881-7554
Fax and phone

CONCORD
130 Pembroke Rd Suite 250
Concord, NH 03301

Authorization to Obtain or Release Information or Records

Client Name: _____ Date of Birth: _____

1. I authorize and request that Willowdale Counseling Center, PLLC:

____ Release to ____ Secure From ____ Exchange With

_____ _____
Name Address

_____ _____
Address Phone Number

2. The specific information to be disclosed is:

_____ Intake/Admission Information
_____ Discharge Summary
_____ Medical Records
_____ Phone Contact
_____ Diagnosis
_____ Treatment Plan
_____ Labs and Diagnostic Screening
_____ Medication List
_____ Psychological Test Results
_____ Treatment Summary
_____ School Records
_____ Billing Information
_____ Family History
_____ Progress Notes
_____ Problem List
_____ Other _____

Special Categories of Information requiring specific approval:

_____ Alcohol & Drug Information (protected pursuant to 42 CFR Part 2)
_____ Sexually Transmitted Disease Information (protected pursuant to RSA 141-C)
_____ Sexual Assault and Domestic Violence Records (protected pursuant to RSA 173)
_____ HIV Test results (protected pursuant to RSA 141-F)

Authorization to Obtain or Release Information or Records

Any/all information relevant to a client's involvement with substances or involvement in treatment of the same shall be protected by the Federal Laws of Confidentiality (42 CFR, Part w) and shall not be disclosed without the written permission of said person. This release shall also expire in six (6) months for alcohol and other drug information or at any time before then at the written request of the client. Redisclosure of alcohol and other drug information received as a result of this release is prohibited.

3. The purpose for release of this information is: _____
_____

4. I have carefully read and understand the above statements, and do herein expressly and voluntarily consent to disclosure of the above information about, or medical records of, my condition to those persons or agencies named above. I further release my attending physician and the hospital or its employees or other responsible parties from any liability arising from the release of this information to such persons or agencies, provided the said release of information is done substantially in accordance with applicable law.

5. I understand that this consent is subject to revocation at any time unless action based on it has already begun.

6. This authorization to Release Information expires in: ___ 30 days ___ 60 days ___ 90 days ___ at termination of treatment ___ 90 days after termination of treatment

_____ _____
Client, responsible person or parent (if minor) Witness

_____ _____
Date Date