WARREN STREET FAMILY COUNSELING ASSOCIATES, INC.

33 Warren Street * Concord, NH 03301

Phone 603-226-1999 Fax 603-224-1675

AUTHORIZATION FOR RELEASE/REQUEST OF CONFIDENTIAL INFORMATION

Permission is hereby give to WARREN STREET FAMILY COUNSELING ASSOCIATES, INC. to ( )release ( )request information from the records of the client listed below.

_____ _____

(Client Name) Date of Birth

_____

Name and address of person/organization to/from which information is to be( )released ( ) requested.

Purpose for disclosure:

List information to disclose, eg, Intake Summary Report, Psychological Evaluation; Psychiatric Evaluations; Treatment Plans; Progress Notes; Medications; Discharge Summary Report. The type of information is limited only to what is necessary to complete the request or release.

Specify how information is to be disclosed:( )copies;( )verbal;( )both

Specify time period from which information is requested/released:
( )from_____to_____ or ( )all dates of service
(date) (date)

Specify if information ( )may or ( )may not be communicated by fax machine.

This authorization expires in one year unless otherwise noted.
Expiration date _____.

I understand that I need not consent to the release of information specified above in order to obtain treatment services. I choose to do so willingly and voluntarily. (This may not pertain to situations where treatment and/or a release of information is court-ordered.) I understand that I may revoke this consent at any time by notifying my therapist or administrative staff at Warren Street Family Counseling Associates, Inc., or by signing the reverse side of this form. I understand that action may have been taken based upon my original consent.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of witness Date

I authorize the release of drug and/or alcohol diagnosis and treatment information.

_____ _____
Signature of client/parent/legal guardian **Date**

_____ _____
Signature of witness **Date**

I authorize the release of communicable/infectious disease information.

_____ _____
Signature of client/parent/legal guardian **Date**

_____ _____
Signature of witness **Date**

Though redisclosure of information released to persons or agencies based upon this authorization is prohibited, such disclosure is out of the control of Warren Street Family Counseling Associates, Inc.

REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION

This consent is subject to revocation at any time except to the extent that action has already been taken on it. I revoke the consent to authorize the ( )release ( )request of information as stated on the reverse of this form. The effective date is _____.

_____ _____
Signature of client/parent/legal guardian Date

_____ _____
Signature of witness Date

PROHIBITION ON REDISCLOSURE

Federal confidentiality rules (42 CFR, Part 2) prohibit you from making any further disclosure of alcohol or drug diagnosis and treatment information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose.