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Counseling Associates of Newport
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(603) 526-4230
(603) 863-1672
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Authorization for Release of Confidential Information

I hereby authorize Counseling Associates of New London, of Newport, & of Claremont
 to: Release Receive Exchange

individually identifiable information from the records of the person named below (which may include information concerning treatment of mental health, treatment for drug and/or alcohol abuse, and/or HIV status).

Name: _____ DOB: _____

Name & Address of Individual &/or Organization to and/or from information is to be released:

Name:	Address:
Telephone:	

Purpose of Disclosure: Coordination of Services or Other: _____
 At the Request of the Individual

<input checked="" type="checkbox"/> Please check one: <input type="checkbox"/> The information to be released is limited to only that which is necessary to carry out the purpose of disclosure. <input type="checkbox"/> I specify that only the following information is to be disclosed:	
<input checked="" type="checkbox"/> Please check one: Specify time period from which information is to be released: <input type="checkbox"/> _____ to _____ Or <input type="checkbox"/> All dates of service.	<input checked="" type="checkbox"/> Please check all those that apply: Specify how information may be disclosed: <input type="checkbox"/> copies <input type="checkbox"/> verbal <input type="checkbox"/> fax
<input checked="" type="checkbox"/> Please check one: <input type="checkbox"/> This authorization expires in one year unless otherwise noted. <input type="checkbox"/> Specified expiration date: _____	

- I understand that I need not consent to the release of information specified above in order to obtain treatment services or have services reimbursed.
- I understand that I may revoke this consent at any time by notifying Counseling Associates of New London, PLLC in writing at P.O. Box 1624, New London, NH 03257, except to the extent it has already been relied upon.
- I understand that there is the potential for this protected health information to be redisclosed by the recipient. If the recipient is not a covered entity (e.g. insurance company, health care provider), the disclosed information may no longer be protected by federal & state privacy regulations.

X _____
 Signature of Client/ Parent/ Legal Guardian

X _____
 Date

 Printed name of Personal Representative

 Legal Authority of Personal Representative

 Witness

 Date