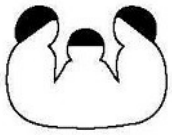


The Counseling Center of Nashua

How to Complete The Counseling Center's Release of Information Form

INSTRUCTIONS

This form is to be used when you want your records from The Counseling Center of Nashua to be sent to an outside source or when you want verbal communication with an outside entity.

Please complete all sections. An incomplete authorization form may result in a delay in processing or the form to be returned to you.

PATIENT INFORMATION SECTION

Complete each line as indicated with the following information:
Patient's Name (Please print clearly)
Patient's Date of Birth
Account Number (if known)
Doctor's Initials (Please note, if you would like all records from all providers, write "TCCON" in this area

RELEASE OF RECORDS SECTION

* Put patient's legal name in the blank to authorize The Counseling Center of Nashua to provide records to or obtain records from.
* Check either box to specify whether you want records provided to (an outside source) or obtained from (an outside source)
* Complete the name of the agency/person to who the records are to be sent to or received from
* Mailing address of who will receive the information ***(Note: this area must be filled out fully or it will be returned to you).***

PURPOSE OF DISCLOSURE SECTION

Check the box (es) that indicates best the purpose for sharing your health information. If no box relates to your purpose, check "Other" and state the purpose.

HEALTH INFORMATION TO BE SHARED (REQUESTING THE FOLLOWING)

Check the box (es) that apply to your request.

SENSITIVE HEALTH INFORMATION SECTION

If you **DO NOT** place initials in these box (es), we **WILL NOT** release the information regarding alcohol/drug use or any information relating to sexually transmitted diseases.

ADDITIONAL INFORMATION

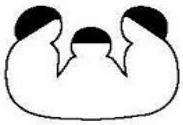
Please read and understand prior to signing the release. There may be a fee involved regarding record releases that are to be acquired for purposes of personal copies or copies sent to lawyers, which must be paid prior to the release of these records.

DELIVERY PREFERENCE SECTION

Please indicate how you would like records to be sent (via fax, mail, or personal pickup). If you are picking up records, please indicate which location you would like to receive these records so that TCCON can have them ready for you.

SIGNATURE

A patient signature is required for all adult patients. If the request is for a minor child, please sign and state your relationship to the patient. Please note that you cannot sign for a legal adult, unless you have a court ordered document stating that you may do so (i.e. Guardianship paperwork).



The Counseling Center of Nashua

The Counseling Center of Nashua Phone: 603.883.0005 Fax: 603.883.0007

ACCOUNT # : _____ Provider(s) _____

PATIENT NAME: _____ PATIENT'S DOB: _____

I, _____, hereby authorize The Counseling Center of Nashua to:
(LEGAL NAME)

RELEASE OF RECORDS
____ PROVIDE TO: _____
Name of Agency/Person
____ OBTAIN FROM:

_____
Address of Agency/Person State Zip

(_____)_____ _(_____)_____
Phone Fax

PURPOSE OF DISCLOSURE (Please check all that apply):

____Co-ordination of Care ____Transfer of Care ____Legal ____ Personal ____Other Please specify _____

Limit records request to the following dates: From _____ to _____ OR Complete Records _____

I AM REQUESTING THE FOLLOWING (Please check boxes that apply):

_____ **This release is for verbal communication only**
_____Release to be place on file for future use – **DO NOT**
SEND RECORDS AT THIS TIME
_____Verbal Communication & Records to be released
_____Psychological Testing Records
_____This release is for Records to be released / received
_____Counseling/Therapy Notes
_____Psychiatric Notes
_____Admission/Discharge Summaries
_____Labs
_____Medication List
_____Letter (Please Specify) _____
_____Other (Please Specify) _____

Please initial if you would like the following information released:
(Federal regulations and state statues prohibit the disclosure of certain information, such as information regarding alcohol and drug treatment, sexually transmitted disease and HIV status, without a separate and specific written consent. (Please **LEAVE BLANK** if you **DO NOT** consent)

Initial: ____ release alcohol/drug information * Initial: ____ release sexually transmitted Information * Initial: ____ release HIV disease information

I understand that:

- A fee for the cost of processing this request may be charged, which is to be paid prior to picking up your records ($ 15.00 for up to the first 30 pages and $0.50 per page thereafter)
- Records can take up to 30 days (from the time of receipt until they are sent out) to process, so please let us know if this is a time sensitive request
- A copy or facsimile of this authorization shall have the same force as the original. The authorization is valid until the end of my treatment at The Counseling Center of Nashua, unless otherwise revoked. I understand I can revoke this release at any time in writing; however, my revocation would not cover action already taken on the basis of this authorization. I further authorize the delivery of this release document to its intended recipient via US Mail or fax.
- Treatment may not be denied because of refusal to sign this authorization, unless the services are being provided for the purpose of providing information to the identified recipient, or if refusal to authorize release of information would compromise competent and informed clinical care. Information released based on this authorization may be subject to re-release by the recipient
- Once this information is shared with the recipient you specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations

DELIVERY PREFERENCE (MUST BE COMPLETED OR FORM WILL BE RETURNED TO YOU)
____Please **mail** to outside source listed above
____Please **fax** to outside source listed above **Attention**_____
____I will **pick up** records at (circle one): **Manchester location** / **Nashua location**

_____ _____ _____
Signature (LEGAL NAME) Date Relationship to Patient (if not signed by patient)

_____
Witness Signature & Title

OFFICIAL USE ONLY ___File ___Send ___Obtain From