AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

*** All sections on authorization form must be completed in order to be valid***

Client Name: _____ **DOB:** _____ **Case #:** _____

I hereby authorize Center for Life Management (CLM) to ☐ **Obtain from** ☐ **Disclose to** ☐ **or Exchange my protected health information including psychiatric/mental health information with:**

Name: _____ ☐ Check if PCP

Address: _____ ☐ Request Records

Phone: _____ Fax: _____ ☐ Send Records

Information to be released / obtained / exchanged (check all that apply):

**please note information to be disclosed is limited to the minimum necessary for the purpose stated below.*

☐ Intake / Assessment ☐ Psychiatric Evaluation / MD Consults ☐ Treatment / Service Plan ☐ Labs

☐ Progress Notes ☐ Complete Record ☐ Other (specify) _____

Dates of treatment: _____ to _____ or ☐ Check here for all dates of treatment

- *I understand that I may inspect or obtain a copy of the protected health information described by this authorization.*
- *I understand that I may revoke this authorization at any time by notifying CLM in writing. However, revocation does not cover information that was received or disclosed prior to CLM receiving revocation.*
- *I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.*
- *I understand that Center for Life Management (CLM) shall not condition treatment on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.*
- *For cases where parents share joint custody; at the discretion of CLM, records released to one parent with joint custody may be disclosed to the other parent without specific request.*

I AUTHORIZE CLM TO RELEASE / OBTAIN THE FOLLOWING INFORMATION:

PLEASE INITIAL AS APPROPRIATE

_____ **Alcohol and/or Drug Treatment Information** (I understand that all related information is protected under Federal Regulation 42 CFR and that I have the right to refuse release.)

_____ ***PLEASE NOTE:** When client is 12 yrs or older and seeking substance abuse treatment independently, client's initials only are needed.

_____ **HIV Related Information** (I understand that I have the right to refuse release.)

The purpose of the release is(Specify): _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

To receiving provider: This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F. R. Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

THIS CONSENT WILL AUTOMATICALLY EXPIRE ON THE CONCLUSION OF YOUR TREATMENT.

Center for Life Management (CLM) - Medical Records Department
10 Tsienneto Road, Derry, NH 03038 - Phone: (603) 434-1577 - Fax: (603) 965-0227