Deborah Warner, Ph.D.
LICENSED CLINICAL PSYCHOLOGIST

Fax 866-599-7012, Phone (603) 444-1512
PO Box 973 Littleton, New Hampshire 03561-0973

Sent ___/___/___
Faxed ___/___/___

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Prohibition of redisclosure: This information is being disclosed from records whose confidentiality is protected by Federal Law 42 CFR Part 2. You are prohibited from making further disclosure of it without the written consent of the person to whom it pertains, or as otherwise permitted by law. A general release does not permit redisclosure of third party materials.

☐ Release Information To:
☐ Obtain Information From:

_____
_____
_____
_____

Pt:_____
DOB:_____

(And Optional: Third Party)

_____
_____
_____

Attention:_____
Phone:_____

I hereby authorize and request the exchange of information between the above-designated parties concerning the patient mentioned above. The following information is requested to be shared:
General Information relating to the psychological functioning of this individual, and specifically to include:

☐ Background	☐ Reports of Discovery	☐ SPEDIS Forms
☐ Observations	☐ Statements to Police	☐ Psych/Soc/Emot Evals
☐ Summaries	☐ Disposition	☐ Teacher Reports & Cards
☐ Test Results	☐ Court Orders	☐ Counselor Reports
☐ Recommendations / Evaluations	☐ Schedule of meetings	☐ Conduct Reports
☐ Medications	☐ Visitation reports	☐ IEPs and 504 plans
☐ Lead levels	☐ Affidavits / Depositions	☐ School - SAU/ Union info

☐ There are no limits placed on dates, history of illness, diagnostic and therapeutic information including any drug and alcohol information or psychiatric information _____

The purpose of this release is to expedite: ☐Counseling ☐Evaluation ☐Referral ☐Continuity of Care

Release of confidential information is subject to State and Federal Laws. By signing this release, I acknowledge my permission to release the above information to &/or from the individual(s) or agency I have named. I understand that the recipient may not maintain the same adherence or obligations as the source with regard to compliance to HIPAA regulations and thus my protected health information may possibly be re-disclosed by the recipient. Except for court-mandated treatment (as provided in HIPAA statute), treatment and coverage eligibility are not conditioned on obtaining the individual's authorization for release of information.

Telefax or Photocopy of this release shall have the full authority of the original.
This release expires 3 months after the completion of care with Dr. Warner. Otherwise, all releases expire one year from date signed, unless otherwise indicated or as otherwise specified by date, event or condition specified here or in state or federal laws. *Optional Expiration Date*:_____

I understand that I may revoke or refuse authorization at any time, except to the extent that action has been taken in reliance on it. ☐ *(check if)* Revocation is documented on reverse of this form.

(Optional section) Telephone permission from _____ on ___/___/___.
Reason for remote authorization _____ Obtained by _____

Signed

_____
Patient (0ver 16 years old)

Date ____/____/____

Signed

_____
Guardian if Patient is under 18

_____
Relationship to patient

Deborah Warner, Ph.D.
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DrWarner@DrDebiWarner.com
(603) 444-2022

This section is for helping locate you in the event of an emergency

The conditions of the release provided are to help determine my whereabouts and well-being and are to be used discreetly to help the therapist locate me and be helpful in supporting my safety. This may be used if I call the Doctor and indicate that I am having an emergency and need such contact, or if the therapist suspects my safety is an issue and determines that it is best to make such contact.

Signed _____ . Date: ____/____/____ Patient

Signed _____ . Date: ____/____/____ Therapist

This section is for the refusal or cancellation of Permission

I understand that I may revoke or refuse authorization at any time, except to the extent that action has been taken in reliance on it. This authorization will expire in 12 months from the date of my signature or as otherwise specified by date, event or condition specified here or in the laws of the state or federal government.

I hereby refuse or cancel the release of information between the Center for New Beginnings and

_____ .

I understand that this begins as of this date and time and does not affect information previously released.

Signed _____ . Date: ____/____/____ time:____:____ am/pm