

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:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Background                    | <input type="checkbox"/> Reports of Discovery     | <input type="checkbox"/> SPEDIS Forms             |
| <input type="checkbox"/> Observations                  | <input type="checkbox"/> Statements to Police     | <input type="checkbox"/> Psych/Soc/Emot Evals     |
| <input type="checkbox"/> Summaries                     | <input type="checkbox"/> Disposition              | <input type="checkbox"/> Teacher Reports & Cards  |
| <input type="checkbox"/> Test Results                  | <input type="checkbox"/> Court Orders             | <input type="checkbox"/> Counselor Reports        |
| <input type="checkbox"/> Recommendations / Evaluations | <input type="checkbox"/> Schedule of meetings     | <input type="checkbox"/> Conduct Reports          |
| <input type="checkbox"/> Medications                   | <input type="checkbox"/> Visitation reports       | <input type="checkbox"/> IEPs and 504 plans       |
| <input type="checkbox"/> Lead levels                   | <input type="checkbox"/> Affidavits / Depositions | <input type="checkbox"/> 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** (Over 16 years old)  
Date \_\_\_/\_\_\_/\_\_\_

Signed \_\_\_\_\_  
**Guardian** if Patient is under 18  
Relationship to patient \_\_\_\_\_

**Deborah Warner, Ph.D.**

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(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

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**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