Authorization to Disclose or Obtain Confidential Information

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Client name Date of birth

I, ______________________________, authorize Allison Carey, LMFT to:

☐ Disclose information to ☐ Obtain information from ☐ Exchange information with

____

Name of person and/or agency

____

Mailing address

____

Phone number Fax number

Type of information (check all that apply): ☐ Verbal ☐ Written

Information pertaining to (check all that apply):

- ☐ Presence in treatment, including mental health treatment, admission and discharge dates
- ☐ Diagnosis, including mental health diagnoses, description of progress, and prognosis
- ☐ Intake and assessment, including medical and psychiatric history
- ☐ Treatment Plan
- ☐ Discharge Summary

This authorization to disclose or obtain confidential information is for the following purpose (check all that apply):

- ☐ History/assessment
- ☐ Development of a treatment plan
- ☐ Ongoing treatment/continuing care
- ☐ Coordination of care
- ☐ Family Communication
- ☐ Insurance, employment, or government benefits

I understand that information disclosed is protected by Federal Regulation 42 CFR Part 2 and 45 CFR Part 164. Information cannot be released without my consent unless otherwise required by law. Redisclosure of this information by the receiving party without my consent is prohibited. I understand that I need not consent to the disclosure of information in order to obtain services except if my record was created to provide information to a third party, for example, under a court-ordered evaluation. I choose to disclose this information willingly and voluntarily for the purposes specified above. I also understand that I may revoke this consent at any time by notifying my therapist <u>in writing</u>. This consent will automatically expire in one year.

Client Signature	Date	Printed Name
Parent/Guardian Signature	Date	Printed Name
Witness Signature	Date	Printed Name

Allison Carey, LMFT, LFYP-1
441 Main Street | Keene, NH 03431 | (603) 903-1414