

Records Release Authorization

FOR THE RELEASE OF PROTECTED MENTAL HEALTH INFORMATION

By signing this form, confidential psychological and psychiatric information can be released to and/or discussed with the people or agencies listed below unless noted by exclusions or limitations. This form is signed voluntarily and may be revoked at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation.

Patient Name: _____

Date of Birth: _____

I. I authorize my provider: Life Management For Adults Phone: (603) 205-2953
P.O. Box 969, Portsmouth, NH 03802 Fax: (888) 499-1213

to **RELEASE** information to the **SECOND PARTY**
as directed below

to **RECEIVE** psychological/psychiatric mental
health information from the **SECOND PARTY**
as directed below

2. **SECOND PARTY** Name: _____

Full Address: _____ Phone #: _____

Email: _____ Fax #: _____

3. **TYPE OF INFORMATION TO BE DISCLOSED** (choose one)

Complete copy of the medical record. I authorize disclosure of all health information, including information relating to medical, pharmacy, mental health, substance abuse, and psychotherapy

I authorize **only the disclosure** of the following information:

4. **PURPOSE** (choose one)

My health information is being disclosed at my request or at the request of my personal representative

My health information is being disclosed for the following purpose:

5. **Note any exclusions or limitations here:** _____

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is not dependent on my signing this authorization. By signing below, I acknowledge that I have read and understand this document and that I have voluntarily given my provider authorization to disclose my records. I understand that I may revoke this authorization at any time by providing a written notice to my provider, however the revocation will not have an effect on any actions taken prior to the date my revocation is received. I understand that my information may be redisclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. This authorization will expire one year following the date signed unless revoked in writing.

Signature of Patient or Legal Representative*

Date

Print Name

Relationship to patient

Acceptance Checkbox * / understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.