WENTWORTH HEALTH PARTNERS

AUTHORIZATION TO RELEASE MENTAL HEALTH RECORDS

Patient Name_____ D.O.B._____

This will authorize _____, to use and/or disclose my
(Name of Entity)

my mental health records for the following purpose:

Name of person or entity **releasing** information:

_____
Name

_____
Street Address

_____
City, State, Zip

_____
Phone Number Fax Number

Name of entity **receiving** information:

Attn:_____
Great Bay Mental Health
15 Old Rollinsford Rd, Suite 302
Dover, NH 03820
Phone: (603) 742-9200
Fax: (603) 742 - 4605

Information to Be Disclosed:

Note: Information to be disclosed may include, as applicable, information related to mental health, drug or alcohol treatment, genetic testing, and HIV/AIDS.

❑ Complete Mental Health Medical Record

OR

❑ Mental Health Medical Records from the following dates: _____ to _____

OR

❑ I only want the following parts of my mental health medical record to be disclosed, I will list them here:

_____

_____

If the choice I made above contains certain information I do not want disclosed, I will list it below:

_____

_____

Patient Name _____ D.O.B._____

- I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION. The Entity listed on page one, releasing my information, will not refuse to treat me based on my refusal to sign the Authorization unless the sole purpose of the requested treatment is to create records for disclosure to someone else. For example, the Hospital may refuse to perform a pre−employment physical for me if I refuse to authorize the release of information obtained during that physical to my employer.

- You may revoke this Authorization at any time, in writing, except to the extent that we have already relied upon it in making a disclosure. Your written revocation will become effective when we receive it. If you are providing this Authorization to obtain insurance coverage, you may not have the right to revoke the Authorization in the future to the extent that it pertains to the insurer's right under law to contest a claim under your insurance policy. If you wish to revoke this Authorization, please send your written request to the **Entity** listed on page one.

- I understand that if I authorize disclosure of protected health information, the recipient may further disclose this information, and Federal law may no longer protect it.

- I understand that I have the right to inspect or receive a copy of the information I am consenting to release.

- Once this Authorization has expired, we will no longer use or disclose your health information for the purpose listed in this Authorization unless you sign a new form. This Authorization expires:

    a. On the following date: _____/_____/_____
    b. When the following event occurs: _____
    c. ❑ Check here if this Authorization is for the purpose of permitting use or disclosure of PHI for the purpose of research − in which case, this Authorization does not expire.
    d. If none of (a) through (c) are completed above, this Authorization will expire 12 months from the date this form is signed.

_____	_____	_____
Printed Name	Signature of Patient or Legal Representative/Guardian **(Legal Handwritten Signature Accepted Only)**	Date

_____

Authority or Relationship of Representative *(Attach copy of documentation of authority)*

TO RECIPIENT OF THIS AUTHORIZATION: This information has been disclosed to you from records whose confidentiality is protected by Federal law. If the information is drug or alcohol abuse treatment information covered by 42 CFR Part 2, federal law prohibits you from making any further disclosures of this information without the specific written authorization to which it pertains.

AUTHORITY: This form is designed to comply with CFR 45 Sec. 164.508.

A copy of this authorization must be provided to the patient.