**AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION – Tressa Ryan Counseling**

**Client Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned, hereby voluntarily authorize that the HIPAA Protected Health Information, consistent with state and federal law noted below be released from my medical, school, and/or mental health record. I request Tressa Ryan to \_\_\_\_\_\_ to release to \_\_\_\_\_\_ to receive from

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The following information:**

* Verbal exchange of information/phone
* Information exchange by fax
* Attendance/non-attendance
* Participation/Compliance with treatment
* Diagnostic summary and diagnoses
* Clinical Progress Notes
* Psychological evaluations
* Intake summary/assessment
* Social/family history
* Treatment Plans and Recommendations
* Discharge summary/prognosis
* Medications and medication history
* Substance use/abuse history

**Purpose of Requested Use or Disclosure**

* Coordination of care, facilitating evaluation, and treatment planning
* At the request of the Patient
* Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Exceptions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Under federal regulation 42CFR, specific types of information are protected and I have the right to refuse release of this information. Initializing any of the items below indicates that I consent to the release of this specific information:

\_\_\_\_\_ Alcohol and/or Drug Treatment \_\_\_\_\_ HIV- related Information

**Notice of Rights and Other Information**

You have the right to revoke this Authorization at any time. To revoke this Authorization, I must send a letter, which has been signed by me or on my behalf to Tressa Ryan, LICSW, 1 Hampton Rd. Suite #303, Exeter, NH 03833. My revocation will be effective upon receipt, but not affect disclosures already made in reliance on prior consent.

This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPPA). Standards for Privacy of Individually Identifiable Health Information (Privacy Standards, 45 CRF 160 and 164 and all federal regulations and interpretive guidelines transmitted there under.

This authorization will remain in effect for one year (unless noted otherwise). I understand that I may revoke this authorization, in writing, at any time, except to the extent of action already taken on my original consent to release protected information.

I understand that once the requested PHI is disclosed, the Privacy Regulations may be subject to re-disclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

(Patient or Authorized Representative)

If signed by someone other than the patient, state your legal relationship to the patient.

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_