Healthy Perspectives – Innovative Mental Health Services, PLLC
30 Temple Street, Suite 105, Nashua, NH 03060
Phone: 603-880-9880 Fax: 603-402-9727

Authorization to Release/Receive Information

All areas must be completed and form signed prior to providing or obtaining information

I, _____, DOB _____ authorize Healthy Perspectives to:

Provide to: _____ Obtain from:_____

_____
Name of Agency/Person

_____
Street Address/City/State/Zip

Phone:_____ Fax: _____

Purpose of Disclosure:_____

Release information below for treatment dates from:_____ to: _____

(check items you wish to have released)					
☐	Intake Assessment Evaluation	☐	Physical Exam	☐	Psychotherapy Notes
☐	Psychiatric Assessment	☐	Clinical Notes	☐	Court Orders
☐	Discharge Summaries	☐	Medications	☐	School Records (IEP, 504 Plan, Etc)
☐	Lab Reports	☐	Drug and Alcohol Info	☐	Telephone/ Verbal
☐	Other (Specify:				

I understand that information disclosed by Federal Regulation 42 CFR, Part 2, 45 CFR Part 160 & 164 (HIPPA) and NH RSA 141-F:8, cannot be released without my consent unless otherwise required by law. I understand that I need no consent to the disclosure of information in order to obtain treatment services. I choose to disclose this information willingly and voluntarily for the purpose specified above. For additional information please refer to Healthy Perspectives' Privacy Policy.

Your initials are required to release the following:

_____ Mental Health _____ Drug/Alcohol _____HIV/AIDS

The information used or disclosed may be subject to re-disclosure by the recipient and no longer be protected by the Privacy Regulations.

You may inspect or copy the protected health information to be used or disclosed under this authorization. You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to Healthy Perspectives, 30 Temple Street, Suite 105, Nashua, NH 03060, and state that you are revoking authorization. Please be sure to include a legible signature and your birth date.

I have read this authorization and I understand it. Unless revoked or a specific date or event is specified, this authorization expires on _____. (Note: The date cannot be greater than one year from date of the patient's signature on this release)

_____ _____
Signature of Individual Date

_____ _____
Signature of individual's Parent/Guardian/Legal Representative Date

_____ _____
Signature of Witness Date