MAPS Counseling Services

Authorization to Disclose or Obtain Confidential Information

☐ 19 Federal Street
Keene NH 03431
603-355-2244

☐ 9 Vose Farm Road
Peterborough, NH 03458
603-924-2240

Fax: 603-355-2299

Client Name : _____ DOB: _____

I, _____ authorize MAPS Counseling Services and _____ to
(Signer's name) *(Therapist's name)*

❒ disclose information to ❒ obtain information from ❒ exchange information with

_____
(Name of person, facility and/or organization)

_____
(Mailing address)

The information covered by this release of information form pertains to (check all that apply):

- ❒ Presence in treatment, including mental health or substance abuse treatment, admission & discharge dates
- ❒ Diagnoses, including psychiatric diagnoses, brief description of progress and prognosis
- ❒ Intake and assessment, including medical/psychiatric history
- ❒ Treatment/Service Plan
- ❒ Discharge Summary
- ❒ HIV Information
- ❒ Substance Abuse Assessment/Treatment Information
- ❒ Other (specify): _____

This information is needed or provided for the following purposes (check all that apply):

- ❒ History/Assessment
- ❒ Development of a Treatment/Service Plan
- ❒ Ongoing Treatment/Continuing Care
- ❒ Coordination of Care
- ❒ Insurance, Employment or Government Benefits
- ❒ Family Communication
- ❒ Other (specify): _____

I understand that the information disclosed is protected by Federal Regulation 42CFR, Part 2 and 45 CFR Part 164. It cannot be released without my consent unless otherwise required by law. Redisclosure of this information without my consent by the receiving party is prohibited. I understand that I need not consent to the disclosure of information in order to receive treatment services except services in a research project or 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 I may revoke this consent at any time by notifying my therapist or case manager in writing.

❒ This consent will automatically expire when my case is closed or in one year, whichever comes first.

- OR -

❒ I am specifying the following date, condition or event upon which it will expire sooner:

_____

_____ _____
Client Signature Date

_____ _____
Parent/Guardian/Legal Representative Signature Date

_____ _____
Therapist or Witness Signature Date