BEDFORD FAMILY THERAPY, LLC
10 Commerce Park North, Unit 1A Bedford, NH 03110 :: Phone/Fax (603) 606-1233

CLIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: _____ Date of Birth: _____

I authorize BEDFORD FAMILY THERAPY, LLC to disclose, receive, and use the above-named individual's health information as described below:

Information may be disclosed to, used by, and received from the following individuals or organizations:

Name: _____

Phone: _____

The type and amount of information to be used or disclosed is as follows (check off the appropriate item(s), and include other information where indicated):

- ☐ Referral/intake information
- ☐ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, recommendations, or testing records and behavioral observations or checklists*
- ☐ Progress notes, treatment plans and similar documents
- ☐ Family, social, educational, and vocational histories and assessments.
- ☐ Termination information
- ☐ Academic and educational records, including achievement and other tests' results, reports of teachers' observations, and all other school or special educational documents*
- ☐ Other: _____

*Items such as educational testing and psychological evaluations produced elsewhere may be received and used only. Bedford Family Therapy will not re-disclose materials produced elsewhere (no secondary disclosure). However, I understand that secondary disclosure by another institution of materials we disclose or send might be beyond our control. If psychological evaluations are created by Bedford Family Therapy, by checking and initialing the relevant item, I understand that I am giving my authorization to disclose and release those evaluations to the above named individuals or organizations.

NOTE TO PATIENT: This authorization may extend to the release of records related to sensitive information including ALCOHOL ABUSE, DRUG ABUSE, SEXUALLY TRANSMITTED DISEASES, PSYCHIATRIC, AND/OR HIV DIAGNOSIS AND TREATMENT.

Please note any limitations or exceptions to this Authorization: _____

Pursuant to the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R Part 2, information pertaining to your alcohol and/or drug treatment are protected and cannot be disclosed without your written consent.

In the event that the release of drug/alcohol use and treatment information is needed for treatment, I authorize its release by checking and signing:

☐ _____

There is also protection from release of information regarding HIV/AIDS/ARC status and treatment, and other sexually transmitted disease information. Should the release of such information be needed or beneficial for treatment, I authorize its release by checking and signing:

☐ _____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Bedford Family Therapy, LLC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire 1 year from the date signed, unless otherwise noted: _____

I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

Signature of Client or Legal Representative: ×_____ **Date:** _____

If signed by legal Representative, relationship to Client: _____ **Date:** _____

Signature of Witness: _____ **Date:** _____