



Between Us Associates, PLLC

Therapeutic Services To Navigate Life's Challenges

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CLIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: _____ Date of Birth: _____

I authorize Between Us Associates, PLLC to exchange the above-named individual's health and treatment related information as described in this Authorization to Disclose Health Information. Information may be disclosed to and received from the following individuals or organizations:

Name: _____ Telephone: _____	Name: _____ Telephone: _____
Name: _____ Telephone: _____	Name: _____ Telephone: _____

The type of information to be received or disclosed is as marked below. Please mark and initial the appropriate items. If you are limiting the scope of release of information to a particular organization, a separate Release form should be used.

- Client referral information
- Progress notes and treatment plans, including diagnoses
- Client/family assessments
- Termination reports and recommendations
- Psychological and psychiatric evaluations and reports*
- Academic and educational records*
- Other: _____

* Items such as educational testing and psychological evaluations produced elsewhere may be received and used only. Between Us Associates 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 Between Us Associates, by checking and initialing the relevant item, I understand that I am giving my authorization to disclose and release those psychological evaluations to the above named individuals or organizations.

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: _____

Please indicate any limitations to this Authorization: _____

You have the right to revoke this authorization at any time. It is our policy that you inform Between Us Associates in writing of your revocation, and that the revocation applies only from the time of our receiving the revocation. When you have authorized release of information to your insurance company and you later revoke authorization, your insurance company may retain right of access to information about treatment when the law and provider contract provide your insurance the right to investigate a policy claim.

Date this authorization will expire: _____ (If blank, one year from signature date)

Client or Legal Representative signature: _____ Date: _____

If signed by Legal Representative, relationship to client: _____

Witness signature: _____ Date: _____