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

PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient 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.
- ☐ HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here. Do not release these __________.
- ☐ Other:

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: ____

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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 Patient or Legal Representative ___________________________________ **Date** __________________

___________________________________ **Date** __________________

If signed by legal representative, relationship to patient ____

Signature of Witness ____ **Date** __________________