Medical Records
The Mental Health Center of Greater Manchester
401 Cypress St.
Manchester, NH 03103
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THE MENTAL HEALTH CENTER OF GREATER MANCHESTER
Authorization for Release of Information

(Please complete ALL sections. Missing information may cause delays or the inability to retrieve your records)

RELEASES CAN TAKE UP TO 15 BUSINESS DAYS TO PROCESS.

FEES: There may be a charge for copying records. Please be as specific as possible about the information you are requesting, as well as the treatment date range.

1. Please print patient name (name of person receiving services)	Name: _____ Case #: _____ Previous Name (if applicable): _____ Date of Birth: _____ Phone #: _____
2. Who can we get your medical record information from? AND/OR **Who** do you want to receive your medical record information?	**Please list the specific hospital, physician office, other agency or support person (One provider/facility/person per release form)** I hereby authorize the facility/provider/support person listed below to: ☐ Release/Obtain medical records ☐ Speak to/discuss with ☐ Both release/obtain medical records and discuss information with Facility/Provider/Person: _____ Address: _____ Phone #: _____ Fax #: _____
3. Protected Health Information to be released: **What** do you want shared?	**__Complete Record (Please be aware that by checking this box you could receive and possibly be charged for items from the record that may not be necessary such as demographic information)** **IF COMPLETE RECORD WAS CHECKED ABOVE, STOP HERE AND MOVE TO SECTION 4.** **If you do not wish to include the complete record, check the items below that you want to share from your record:** ☐ Assessments ☐ Treatment Plans/Reviews ☐ Progress Notes ☐ Summaries ☐ Treatment Status ☐ Insurance/Billing ☐ Diagnosis ☐ Letters/Forms ☐ Demographics Info ☐ Medical Screening ☐ Legal Docs (specify; e.g., CD, Guardianship)_____ ☐ Research Records **– include all items protected under a Certificate of Confidentiality** ☐ **Yes** ☐ **No** ☐ Physician Orders/Med List (NOTE: Your medication history may include dates outside the "treatment dates" specified above. **THIS RELEASE COVERS ALL TREATMENT DATES UNLESS A PARTICULAR DATE(S) ARE SPECIFIED BELOW:** From: _____ To: _____ **(We do not accept "All" for dates of service)** Is this request for us to obtain psychotherapy notes? (**these are notes that exist outside the patient record)** ☐ Yes, then this is the only item you may request on **this** authorization
4. **IMPORTANT**	It is extremely important that you select either **"YES"** or **"NO"** for each item contained in this section. ☐ Yes ☐ No – Information can be obtained/released concerning my alcohol or substance use disorder (SUD) treatment ☐ Yes ☐ No – Information can be obtained/released concerning my HIV/AIDS status
5. Purpose of Release (Why is it needed?)	☐ Continuing Care ☐ Transfer of Care ☐ Personal Use/Review ☐ Insurance/Benefits ☐ Attorney/Legal ☐ Discharge Planning ☐ Care Coordination ☐ Treatment Planning

CONTINUED ON NEXT PAGE

Patient Name: _____ Case #: _____

I understand that:

1. I am consenting to the releasing and/or obtaining of psychiatric information.
2. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. The information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by the Privacy Regulations.
5. Federal rules 42CFR Part 2 prohibits further disclosure of SUD information unless expressly permitted by written consent and restricts any use of information to investigate or prosecute with regards to a crime any patient with a substance use disorder, except in connections with a crime committed on the premises or against a SUD provider, or consistent with 42 CFR Part 2 section 2.65.
6. I understand that I have a right, upon request, to a list of entities to which my information has been disclosed pursuant to the general designation.

This release expires six months following my discharge from The Mental Health Center unless a shorter period is specified here: _____.

For persons whose case is closed at the time this release is completed, the release will expire in 6 months unless a shorter period is specified here: _____.

_____ _____

Signature of Patient/Former Patient Date (REQUIRED)

OR

_____ _____

Signature Parent/Legally Authorized Representative Date (REQUIRED)

_____

Printed Name of person signing **&** Relationship of person signing (e.g., Parent, Guardian, Power of Attorney)

MHCGM STAFF USE:

☐ Patient requested copy of Authorization to Release Information