



Counseling Associates of MA & NH, LLC

Child, Adolescent, Adult, Couple, and Family Psychotherapy

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RELEASE OF INFORMATION

I, (client name) _____, DOB _____, give permission for _____ (name of psychotherapist), to speak with the following person or persons in order to share information regarding my psychotherapy treatment about myself (or my child) _____ DOB _____.

This permission is good for:

- | | |
|--|--|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Drug and Alcohol Use |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Medical Information |
| <input type="checkbox"/> Psychosocial Evaluation | <input type="checkbox"/> Educational Information |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Discharge/Transfer Summary |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Continuing Care Plan |
| <input type="checkbox"/> Treatment Plan or Summary | <input type="checkbox"/> Progress in Treatment |
| <input type="checkbox"/> Current Treatment Update | <input type="checkbox"/> Demographic Information |
| <input type="checkbox"/> Medication Management Information | <input type="checkbox"/> Psychotherapy Notes |
| <input type="checkbox"/> Presence/Participation in Treatment | <input type="checkbox"/> Any information relevant to psychotherapy |
| <input type="checkbox"/> HIV status | <input type="checkbox"/> Other: _____ |

NAME of PROVIDER: _____

ADDRESS: _____

PHONE: _____ FAX: _____

- I understand that I have the right to rescind this release at any time by writing the above-named psychotherapist that I choose to rescind this permission. I further understand that a revocation of the authorization is not effective to the extent that action has been taken prior to the release being revoked.
- I understand that protected health information disclosed under this release may be re-disclosed by the recipients(s) to other individuals or organizations that are not subject to privacy protection laws. I hereby release the above-named psychotherapist, from all legal responsibilities and liabilities that may arise from the release of such protect health information.
- I understand that this release is valid until _____ or one year from date of this document.

Client signature

Date:

Or

Signature of personal representative of client:

Date

If signed by a personal representative, state your relationship to patient and/or reason and legal authority for signing below.

Client is: minor incompetent disabled deceased
Legal authority is: parent legal guardian next of kin of deceased