NEURODEVELOPMENTAL INSTITUTE OF NEW HAMPSHIRE

OPTIMIZING POTENTIAL THROUGHOUT THE LIFESPAN

www.ninhllc.com

Authorization to Obtain and/or Release Information

Client Name: _____ DOB: _____

I, the undersigned, understand that consent for release of information is not a required condition for treatment and that I hereby voluntarily authorize that Protected Health Information (including psychiatric) be:

☐ **PROVIDED TO**: ☐ **OBTAINED FROM**:

_____

Agency/Person Name | Agency/Person Address

_____ _____

Telephone | Fax Number

Select One of the Following:

☐ This release covers all treatment dated up to the date signed below, OR;
☐ This release covers all treatment dates and continues through my current episode of care, OR;
☐ This release only covers treatment dates ____/____/_____ through ____/____/_____

Check all that you wish to have released:

☐ Academic Testing Results
☐ Assessments
☐ Behavior Program
☐ Case Notes
☐ Intelligence Testing Results
☐ Medical Reports
☐ Medication Lists
☐ Neuropsychological Testing
☐ Personality Profiles
☐ Progress Notes
☐ Psychological Reports
☐ Psychological Testing Results
☐ Service Plan
☐ Summaries
☐ Treatment Plans/Reviews
☐ Vocational Testing Results
☐ Other: (specify)
_____
_____
_____

THE FOLLOWING REQUIRES A SEPARATE AUTHORIZATION AND MAY NOT BE COMBINED WITH ANY OTHER CHECKED ITEMS

☐ Psychotherapy notes may be **released to** the Neurodevelopmental Institute of New Hampshire

Initial below to authorize release of protected information:

_____ I specifically authorize disclosure of information concerning my *alcohol or drug abuse treatment*. I understand that all related information is protected under Federal Regulation 42 CFR and that I have the right to refuse release.

_____ I specifically authorize disclosure of information concerning my *HIV/AIDS status*. I understand that I have the right to refuse release.

The purpose of the release is:

☐ Treatment Planning ☐ Eligibility ☐ Evaluation ☐ Discharge/Aftercare Planning
☐ Legal (specify): _____ ☐ Other (specify): _____

Unless otherwise indicated, this release authorized the sharing of information verbally, written and electronically.

☐ I am requesting that you send written and/or electronic information as soon as possible upon receipt of this request.

I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it. The information used or disclosed may be subject to re-disclosure by the recipient and no longer be protected by the Privacy Regulations. This release expires six months following my discharge from the Neurodevelopmental Institute of New Hampshire 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 six months unless a shorter period is specified here: _____.

_____

Signature of Client/Former Client | Date

_____

Parent/Guardian/Legally Authorized Representative | Date

_____

Print Parent/Guardian Name OR Describe Authority of Legal Authorized Representative