AUTHORIZATION FORM

I, ______________________________________DOB:________ authorize my clinician(s),_____________________ of **GREAT BAY MENTAL HEALTH ASSOCIATES, Inc.** at 311 Route 108, Suite 204, Somersworth, NH 03878, (Phone 603-742-9200 and Fax 603-742-4605) and/or his or her administrative staff GBMHA to:

__________Request/ Use the following protected information
__________Release/ Disclose the following protected information

Name of Entity to Receive/ Disclose the Information;

Name ____

Address ____

____

Phone # ______________________________ Fax # ______________________________

Information to be Disclosed; __________ Psychiatric/psychological evaluation
__________ Progress notes
__________ Other: ____

Purpose of Release; Collaboration________ Treatment Planning ________ Other_________________________________

Methods of Disclosure Authorized; _____ Faxed _____ Written _____ Phone Conversation _____ In Person _____ E- Mail

This Authorization is effective until ____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. Revocation will be effective as of the date received. I understand that a revocation will not be effective to the extent that the provider has taken action in reliance on the authorization prior to the revocation date, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my clinician generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule. I understand that I have the right to: -1.Inspect or copy the protected heath information to be used or disclosed as permitted under Federal law 2. Refuse to sign this authorization.

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided. ____

****SIGNATURE OF PATIENT** ____ Date ________________

I authorize the release of drug and/ or alcohol diagnosis and treatment information.

****SIGNATURE OF PATIENT** ____ Date ________________

I authorize the release of information relating to psychological services performed by the above named staff at GBMHA.

To the Receiving Provider : This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical information or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.