WENTWORTH HEALTH PARTNERS

Great Bay Mental Health
15 Old Rollinsford Rd, Suite 302, Dover, NH 03820 Phone: 603-742-9200 Fax: 603-742-4605

AUTHORIZATION TO RELEASE MENTAL HEALTH PSYCHOTHERAPY RECORDS

Patient Name_____ D.O.B._____ MR#_____

This will authorize Great Bay Mental Health Associates and its related entities to use and/or disclose my protected health information contained in my mental health records for the following purpose:

❑ Name of person or entity receiving information:_____

_____

Street Address City State Zip Code Phone Number

Information to Be Disclosed:

Note: Information to be disclosed may include, as applicable, information related to mental health, drug or alcohol treatment, genetic testing, and HIV/AIDS.

❑ Complete Mental Health Medical Record

OR

❑ Mental Health Medical Records from the following dates: _____ to _____

OR

❑ I only want the following parts of my mental health medical record to be disclosed, I will list them here:

_____

_____

If the choice I made above contains certain information I do not want disclosed, I will list it below:

_____

_____

Method of Delivery: ❑ Mail to receiving entity above ❑ I will pick up

❑ Designee will pick up (specify below) ❑ Other _____

To be completed if Designee will pick up records:

I allow _____, my designee, to pick up the medical records identified above since I am
Print Name
unable to do so myself.

My designee may pick up my medical records for the time period I have checked below:

- ❑ One time only − once my designee picks up my medical records, that person may not pick up my medical records in the future unless I sign another copy of this document.
- ❑ Indefinitely − my designee may pick up my medical records until I revoke the authority of my designee or until this PHI Release form expires or is revoked by me.

- I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION. Great Bay Mental Health Associates, and its related entities, will not refuse to treat me based on my refusal to sign the Authorization unless the sole purpose of the requested treatment is to create records for disclosure to someone else.

Patient Name _____ D.O.B._____ MR#_____

- You may revoke this Authorization at any time, in writing, except to the extent that we have already relied upon it in making a disclosure. Your written revocation will become effective when we receive it. If you are providing this Authorization to obtain insurance coverage, you may not have the right to revoke the Authorization in the future to the extent that it pertains to the insurer's right under law to contest a claim under your insurance policy. If you wish to revoke this Authorization, please send your written request to: **Wentworth-Douglass Hospital, Attn: Medical Information Department, 789 Central Avenue, Dover, NH 03820.**

- I understand that if I authorize disclosure of protected health information, the recipient may further disclose this information, and Federal law may no longer protect it.

- I understand that I have the right to inspect or receive a copy of the information I am consenting to release within the established policies of Great Bay Mental Health Associates, and its related entities.

- Once this Authorization has expired, we will no longer use or disclose your health information for the purpose listed in this Authorization unless you sign a new form. This Authorization expires:

  a. On the following date: _____/_____/_____
  b. When the following event occurs: _____
  c. ❑ Check here if this Authorization is for the purpose of permitting use or disclosure of PHI for the purpose of research − in which case, this Authorization does not expire.
  d. If none of (a) through (c) are completed above, this Authorization will expire 12 months from the date this form is signed.

_____ _____ _____

Printed Name | Signature of Patient or Legal Representative/Guardian | Date

(Legal Handwritten Signature Accepted Only)

_____

Authority or Relationship of Representative *(Attach copy of documentation of authority)*

TO RECIPIENT OF THIS AUTHORIZATION: This information has been disclosed to you from records whose confidentiality is protected by Federal law. If the information is drug or alcohol abuse treatment information covered by 42 CFR Part 2, federal law prohibits you from making any further disclosures of this information without the specific written authorization to which it pertains. AUTHORITY: This form is designed to comply with CFR 45 Sec. 164.508.

A copy of this authorization must be provided to the patient.

☐ Approve release of information ☐ Deny release of information

_____ _____ _____

Print Name of Great Bay Mental Health provider | Signature of Great Bay Mental Health provider | Date

For Hospital Patient Transfer:
Request Processed and Records Sent with Patient By: Staff Initials_____ Date_____

For Medical Information use only:
□ Patient picked up □ Mailed to patient □ Mailed to receiving entity □ Other_____ Date: _____

Completed By: Staff Initials_____ Date_____

□ ***A copy of this signed authorization has been included with the records provided to the patient.***

For Designees/Patients picking up records only (signature will be obtained by Medical Information at time of pick up):

Signature _____ Printed Name _____ Date_____