Allison L. Sharpe LCMHC, PLLC
COUNSELING & PSYCHOTHERAPY

**154 Broad Street # 1527 | Nashua, NH 03063**
**Phone: 603-236-7774**

# Authorization Form for Allison L. Sharpe LCMHC, PLLC

This form when completed authorizes me to release or obtain protected information from your clinical record.
1) I _____ (name) authorize _____and/or his or her administrative and clinical staff to release / obtain (circle) the following information from the record of _____:

- ☐ A complete copy of my medical record, including psychotherapy notes.
- ☐ Information pertaining to alcohol and other substance abuse (42CFR, part 2). *
- ☐ HIV Status (NH RSA 141-F8).
- ☐ Only the following specific information: _____

_____
_____

2) This information should only be released to / obtained from (circle one) the following person(s):

| Name | Address | Phone/Fax |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

3) I am requesting this information be released for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

_____

4) This authorization shall remain in effect until (fill in expiration date or fill in an event that relates to the individual or the purpose of the use or disclosure). _____

5) I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. However, your revocation will not be effective to the extent that information has been released prior to the revocation, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6) I understand that my counselor generally may not make the provision of services conditional upon my signing an authorization, unless these services are provided to me for the purpose of creating health information for a third party.

7) I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Signature of Patient or Representative | Printed Name | Date | Date of Birth |

8) 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 below:

_____

* This information has been disclosed to you from our records and is protected by federal confidentiality rules (42 CFR 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 is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical 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.