**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**
***All sections on authorization form must be completed to be valid***

NAME_____DOB_____RECORD#_____

I hereby authorize PASTORAL COUNSELING SERVICES (PCS) to: ☐ Obtain ☐ Disclose or ☐ Exchange my protected health information (including psychiatric/mental health information with):

Name _____

Address _____

Phone _____ Fax_____

Information to be released/obtained/exchanged **(check all that apply)**:
*Please note information to be disclosed is limited to the minimum necessary for the purpose stated below:*

☐ Intake/Assessment ☐ Treatment/Service Planning ☐ Progress Note

☐ Coordination of Treatment ☐ Other (specify): _____

The purpose of the release (specify): _____

Dates of treatment: _____ to _____ Check here for all dates of treatment

- ✓ *I understand that I may inspect or copy the protected health information described by this authorization.*
- ✓ *I understand that I may revoke this authorization at any time by notifying PCS in writing. However, revocation does not cover information that was received or disclosed prior to PCS receiving revocation.*
- ✓ *I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.*
- ✓ *I understand that Pastoral Counseling Services (PCS) shall not condition treatment on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.*
- ✓ *For cases where parents share joint custody: at the discretion of PCS, records released to one parent with joint custody may be disclosed to the other parent without a specific request.*

*I AUTHORIZE PCS TO RELEASE THE FOLLOWING INFORMATION: **PLEASE INITIAL** AS APPROPRIATE*

_____**Alcohol and/or Drug Abuse Treatment Information:** I understand that all related information is protected under Federal Regulation 42 CFR and that I have the right to refuse release.

_____**HIV Related Information:** I understand that I have the right to refuse release.
Please note: If client is 12 years of age or older, this area needs to be initialed by CLIENT: Parent's initial alone are not sufficient.

Client: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____

THIS CONSENT WILL AUTOMATICALLY EXPIRE IN 1 YEAR
Otherwise, specify a date, condition, or event upon which it will expire sooner.

Pastoral Counseling Services (PCS)
2013 Elm Street, Manchester, NH 03104 Phone: 603-627-2702 Fax: 603-627-3643