Dynamic Mental Health of New England

Authorization for Release of Information

Instructions: Please fill out this form to allow communication between Dynamic Mental Health of New England, PLLC (DMHNE) and others (family members, outside healthcare providers, etc.) that you wish to be able to share your healthcare information.

Fill out one copy of this form for EACH person, healthcare provider, or organization that you wish to be able to share information with DMHNE.

Name of patient: _____

Patient's date of birth: _____

Authorization is given by the above-named patient (or their guardian or legal representative) for DMHNE to disclose to and/or obtain information from the following person, health care provider, or organization:

Name of person, outside healthcare provider, or organization: _____

_____

Address and phone number of the person, provider, or organization (and fax number, if known):

_____

_____

The above-named patient (or their guardian or legal representative) authorizes the following type(s) of information to be disclosed:

☐ Psychiatric/psychological assessment, diagnosis, and treatment notes

☐ Diagnostic/evaluation test results

☐ Laboratory findings

☐ Treatment plan or summary

☐ Discharge or transfer summary

☐ Substance use assessment or treatment notes

Purpose: This information may be used or disclosed in connection with the patient's mental health treatment, payment, or healthcare operations.

Revocation: I understand that I have the right to revoke this authorization at any time by sending written notification to DMHNE. I further understand that a revocation of the authorization is not effective to the extent that action has previously been taken in reliance on the authorization.

Expiration: Unless sooner revoked, this authorization expires after:

☐ One month

☐ Six months

☐ One year

Conditions: I further understand that DMHNE will not condition my treatment on whether I give authorization for the requested disclosure.

Form of Disclosure: I authorize DMHNE and the above-named outside provider or organization to disclose information as permitted by this authorization in any matter deemed appropriate by those parties, consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

Signature of Patient:

_____ Date: _____

Name of Guardian/Representative of the Patient (if applicable):

_____

Signature of Guardian/Representative of the Patient (if applicable):

_____ Date: _____

If signing as a guardian or legal representative of the patient, please describe your authority to act for this individual (parent with legal decision-making authority, power of attorney, healthcare surrogate, etc.):

_____

If records have been requested, they may be faxed to 949-561-5020 (preferred) or mailed to:

Dynamic Mental Health of New England
80 Palomino Lane, Suite 203
Bedford, NH 03110

If you have any questions, please call the office at 603-716-1924.