Heal Together Counseling, LLC
194A Pleasant Street, Suite 206
Concord, NH 03301
Phone: 401-584-4325
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Release of Information

By signing this form, I authorize the release of my confidential health information to the identified party listed below.

Client Name: ______________________________ Date of Birth: __________________________

This release allows Heal Together Counseling, LLC:

☐ To disclose information to the party listed below	☐ To receive information from the party listed below

Agency: ______________________________________ Phone: _________________________

Address: ____

Contact person (if applicable): ____

The purpose of this release is for:

☐ Treatment Planning	☐ Care Coordination	☐ Evaluations
☐ Discharge Planning	☐ Other:	

I consent to releasing the following information:

☐ Complete Record	☐ Progress Updates	☐ Medications
☐ Treatment Plan	☐ Safety Plans	☐ School Records
☐ Progress Notes	☐ Court Orders	☐ Discharge Summary
☐ Physical/Immunizations	☐ Client acknowledgement	☐ Attendance
☐ Evaluations	☐ Medical Records	☐ Recommendations
☐ Treatment Summary	• Other:	

Release of Information Acknowledgements:

- I understand and acknowledge that signing this release of information is voluntary. Refusal to sign this release will not prevent me from accessing treatment.
- I understand and acknowledge that this signed release authorizes verbal and written communication by the identified parties. This includes electronic communications as well.
- I understand that alcohol/drug treatment records are provided additional protections under the federal law and cannot be disclosed without written consent unless otherwise determined by federal regulations.
- I understand that this release may be revoked at any time. Revocation of a previously signed release must be done in writing. Heal Together Counseling cannot be held liable for any information disclosed when a signed release is on file and no revocation has occurred.
- I understand that Heal Together Counseling cannot be held liable for any use of distributed information that is provided to a third party when a signed release is in effect.

Unless written revocation of this release is provided to Heal Together Counseling, this authorization to disclose information will remain in effect for twelve (12) months from the date of the authorized signature.

Signature:
By signing below, I hereby authorize Heal Together Counseling to disclose the records of the identified individual to the identified agency. If the identified individual is a minor, I acknowledge my legal authority to sign releases for the identified individual and authorize disclosure of records.

____________________	____________________
Client/Parent/Guardian Signature	Date
Client/Parent/Guardian Name	Therapist Signature
Relationship to Client	