ENDURANCE
BEHAVIORAL HEALTH PLLC

P.O. Box 2899, 867 Lafayette Rd.
Seabrook, New Hampshire 03874
p 603-760-1942 f 603-760-1949
endurancebehavioralhealth.com

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Date of Birth:________________________
I authorize Endurance Behavioral Health to release/disclose Protected Health Information about me

To: _________________________________ Address: ___________________________ Phone:__________________
____

The information to be disclosed includes____*(medical record, lab results, billing information, etc.)*. **If psychotherapy notes are authorized to be disclosed in addition to any other type of information, a *separate* authorization must be provided.** The information may be used for the purpose of ____.

The information to be disclosed will be in the form of ____ (*an electronic copy of my Electronic Health Record, verbal or oral information, or a paper copy of my Protected Health Information.)*

- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by Federal or State privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- I understand that my clinician generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.
- I understand that I may revoke this authorization in writing at any time by notifying Endurance Behavioral Health, PLLC except to the extent that action has been taken in reliance on this authorization. This authorization expires ___________ *(insert applicable date or event).* If left blank, authorization will expire one year from the date signed.

To the extent my record contains information about HIV test results ______, mental health records_____, substance abuse records______ or genetic testing______, I hereby grant authorization to release such information. **(Patient/representative must initial each item above to be released.)**

____ ________________________
Signature of Patient or Representative Date

____ ____
Patient Name Name of Patient Representative Date

(A copy of this signed form will be provided to the patient)

[1] Psychotherapy notes document or analyze the contents of conversation during a private counseling session or a group, joint, or family counseling session.
[1] If the authorization is initiated by the individual, and the individual elects not to state the purpose, it is sufficient to state that the information is disclosed "at the request of the individual."