



# Maps Counseling Services

## Authorization to Disclose or Obtain Confidential Information

23 Central Square, Suite 300  
Keene NH 03431-3774  
603-355-2244

9 Vose Farm Road  
Peterborough, NH 03458  
603-924-2240

Fax: 603-355-2299

Client Name : \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_ authorize Maps Counseling Services and \_\_\_\_\_ to  
(Signer's name) (Therapist's name)

disclose information to  obtain information from  exchange information with

\_\_\_\_\_  
(Name of person, facility and/or organization)

\_\_\_\_\_  
(Mailing address)

The information covered by this release of information form pertains to (check all that apply):

- Presence in treatment, including mental health or substance abuse treatment, admission & discharge dates
- Diagnoses, including psychiatric diagnoses, brief description of progress and prognosis
- Intake and assessment, including medical/psychiatric history
- Treatment/Service Plan  Discharge Summary
- HIV Information  Substance Abuse Assessment/Treatment Information
- Other (specify): \_\_\_\_\_

This information is needed or provided for the following purposes (check all that apply):

- History/Assessment  Development of a Treatment/Service Plan
- Ongoing Treatment/Continuing Care  Coordination of Care
- Insurance, Employment or Government Benefits  Family Communication
- Other (specify): \_\_\_\_\_

I understand that the information disclosed is protected by Federal Regulation 42CFR, Part 2 and 45 CFR Part 164. It cannot be released without my consent unless otherwise required by law. Redisclosure of this information without my consent by the receiving party is prohibited. I understand that I need not consent to the disclosure of information in order to receive treatment services except services in a research project or if my record was created to provide information to a third party, for example under a court-ordered evaluation. I choose to disclose this information willingly and voluntarily for the purposes specified above. I also understand I may revoke this consent at any time by notifying my therapist or case manager in writing.

This consent will automatically expire when my case is closed or in one year, whichever comes first.

- OR -

I am specifying the following date, condition or event upon which it will expire sooner:

\_\_\_\_\_

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian/Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist or Witness Signature

\_\_\_\_\_  
Date