



DMC Behavioral Health
14A Tsienneto Road, Suite 301
Derry, NH 03038
Telephone: 603-845-5934
Fax: 603-425-2378

AUTHORIZATION TO USE/DISCLOSE BEHAVIORAL HEALTH TREATMENT INFORMATION

Patient Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

I hereby authorize DMC Behavioral Health (Derry Medical Center) Counseling Services to:

RELEASE TO \_\_\_\_ or RECEIVE FROM \_\_\_\_ (check ONE)

FACILITY: \_\_\_\_\_ PROVIDER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

FAX: \_\_\_\_\_ PHONE: \_\_\_\_\_

INFORMATION TO BE DISCLOSED TO INCLUDE:

Please initial all APPROVED fields below.

- \_\_\_\_\_ All behavioral health notes and treatment
\_\_\_\_\_ Chart Abstract (3 years of treatment)
\_\_\_\_\_ Last three behavioral health notes
\_\_\_\_\_ Specific Documents
\_\_\_\_\_ Additional notes/other \_\_\_\_\_

Reason for the Request: \_\_\_\_\_

I have marked the information I consent to be shared with the requester. I understand the scope of this authorization and agree to it. I understand that I am entitled to receive a copy of the information by requesting it in writing. I voluntarily authorize this release as described above and understand that if I decline to authorize all items as listed above that I may be declined for care. I understand that I have a right to revoke this authorization at any time as long as I do so in writing.

Signature of patient

Date

Signature of parent, guardian or representative

Date

Printed name of parent, guardian or representative

Date