



Behavioral Health
Release Form
For Use and Disclosure of

14A Tsienneto Road, Suite 301
Derry, NH 03038
Phone – 603-845-5934
Fax – 603-425-2378

Patient Name _____ Date of Birth: _____

Address: _____ Phone #: _____

I hereby authorize DMC Primary Care (Derry Medical Center) Counseling Services to obtain medical records from the Practice/Provider listed below:

Practice/Provider: _____

Address: _____ Phone: _____

The Following Protected Health Information is included in the request. Please initial all APPROVED fields below.

- _____ Intake/ Evaluation Notes ;
- _____ Three Most Recent Behavioral Health notes;
- _____ Medication Management Notes, if any;
- _____ Discharge Summaries (any);
- _____ **ALL** Behavioral Health Notes

Reason for Request: _____

Authorization Statement: "I hereby authorize DMC Primary Care and Behavioral Health to use and disclose my commingled health records, including general medical, mental health, and substance use disorder (SUD) diagnosis, treatment, or referral information."

I authorize _____ to disclose information to _____ for the purpose of

[e.g., ongoing care coordination, treatment planning, insurance billing, or referral to a new provider].

Patient Signature _____ Date: _____

Expiration and Revocation: "This consent expires two years from the date of signature. I understand I may revoke this consent in writing at any time, except when action has already been taken based upon it. 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 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

42 CFR Part 2 was created in 1972 to protect the privacy and confidentiality of substance use disorder (SUD) treatment records. It ensures that patients can seek help for drug and alcohol issues without fear of social stigma, discrimination, job loss, or criminal prosecution from the disclosure of their medical information.

To the Recipient: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

Signature of patient _____ Date _____

Printed Name of Patient _____

Signature of parent/guardian/representative _____ Date _____

Printed name parent/ guardian/representative _____