C.R.E.A.T.E!
Center for Expressive Arts, Therapy and Education, P.L.L.C.
141 Union St
Manchester, NH 03103
603-625-0010

Release of Information Form

NOTE: Only ONE release per form. Please use a separate form to indicate release of information to other agencies, individuals, etc.
(please print)

RE:_____ DOB:_____ SS#:_____
Minor ( ) Yes ( ) No

I authorize **physical summary, immunizations, medications and allergies** information from my records to be exchanged between C.R.E.A.T.E! Center for Expressive Arts, Therapy and Education, P.L.L.C. and:
PCP:_____

This information is to be used specifically for: **COORDINATION OF CARE**

- I understand that my healthcare and payment for my healthcare may continue if I do not sign this form. However, I do understand that if I refuse to allow C.R.E.A.T.E! to procure certain information, that the quality of my treatment may be compromised, and under certain circumstances, may result in the termination of the treatment.
- This form was completely filled in *before* I signed it.
- I certify that all of my questions were answered to my satisfaction, and I understand this authorization form and all of its contents.
- I expressly acknowledge that this authorization is voluntary.
- I authorize the use of any translator who is required in order for me to receive services.
- I understand, once information is sent outside this office, C.R.E.A.T.E! cannot control and is no longer responsible for its use or dissemination.

Client Declines:_____ **Date:**_____

_____ _____
Signature Self ( ) Parent ( ) or Guardian ( ) Date

_____ _____
Print Self ( ) Parent ( ) or Guardian ( ) Date

_____ _____
Witness Date

_____ _____
Print Date

All information with reference to this release will expire two years from the date signed OR upon closure.

When alcohol and/or drug use/abuse may be disclosed, I understand that my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event, this consent expires automatically as detailed above:

***In addition to mental health treatment released above, I also authorize the following specific information to be released: (initial the area and sign below)**

_____ **Medication**
_____ **HIV or any other STD**
_____ **Domestic Violence Reports to Court**
_____ **Anger Management Reports to Court**
_____ **Court Ordered Screenings and/or Evaluations**
_____ **Substance Use and/or Abuse**

_____ _____
Signature Self ( ) Parent ( ) or Guardian ( ) Date

_____ _____
Print Self ( ) Parent ( ) or Guardian ( ) Date

_____ _____
Witness Date

_____ _____
Print Date

All information with reference to this release will expire two years from the date signed OR upon closure.