C.R.E.A.T.E!

Center for Expressive Arts, Therapy and Education, P.L.L.C.
141 Union Street
Manchester, NH 03103
603-625-0010

Release of Information Form (PCP)

RE: _____ **D.O.B.:** _____
Client's Name **Minor ( ) Yes ( ) No**

I authorize any and all 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: my (or my child's) PCP, who is _____ located at _____
(Doctor's Name)

This information is to be used specifically for treatment, updates, reports, and coordination of care.

- I understand that this consent to release information may be revoked in writing by me at any time. If revoked, no further information will be provided. However, the cited recipient will be notified of the revocation.
- 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 filled in completely before I signed it.
- I certify that all my questions were answered to my satisfaction, and I understand this authorization form and all its contents.
- I expressly acknowledge that this authorization is voluntary.
- I authorize the use of any translator who is required 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.

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

_____
Print

_____ _____
Witness Date

_____
Print

Client Declines ☐ _____ **Date** _____

All information with reference to this release will expire <u>two years</u> 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.
In addition to mental health treatment released above, I also authorize the following specific information to be released:
(initial & sign below)

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

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

_____
Print

_____ _____
Witness Date

_____
Print

NOTE: <u>Only ONE release per form</u>. Please use a separate form for other agencies, individuals, etc. Please print.
All information with reference to this release will expire <u>two years</u> from the date signed OR upon closure. Rev.2019