Sarah C. Benoit, LCMHC, LMHC, PLLC
468 Route 13 South
Milford, New Hampshire 03055
603-672-4497

Authorization to Use and/or Disclose Protected Health Information

This form fully protects your right to confidentiality when:

1) You sign this release voluntarily. You are not signing the form as a required condition of treatment.
2) All blanks are filled on the form before you sign it.
3) You sign this form only after specific request for specific information has been made.

[Print name of client] _____, date of birth _____
Authorizes Sarah C. Benoit, LCMHC, LMHC, PLLC to obtain and/or disclose my protected health information from/to/with:
(Name and Address of Recipient)_____

The Purpose of this disclosure/sharing of information is to improve assessment and treatment planning, share information relevant to treatment when appropriate and coordinate treatment sessions. I authorize the mutual exchange of ongoing case progress with Sarah C. Benoit, LCMHC, LMHC, PLLC during the time covered by this release.
Consumers retain the right to authorize disclosure even without a specific purpose of disclosure. If intent of this release is other than these listed, please state purpose and initial.

Information to be released by above:

- Intake Assessments/Evaluations
- Treatment/Clinical Notes
- Treatment Plans and/or Discharge Summaries
- Psychiatric Evaluations/Assessments
- All Protected Health Information (Full Record)
- Other

Information to be released to above:

- Evaluations
- Treatment/Clinical Notes
- Treatment Plans and/or Discharge Summaries
- Relevant hospital records
- School Records (IEP, 504 Plan, etc.)
- Court Orders
- Other

The following items **must be initialed by you and/or your guardian to be included in the use or disclosure of other protected health information:
_____ **Mental health information and/or records
_____ **Drug/alcohol diagnosis, treatment and/or referral information. (Federal regulations require a description of how such and what kind of information is to be disclosed. Federal law prohibits the redisclosure of such information.)
_____**HIV/AIDS related health information and/or records

Except to the extent that action has already been taken based upon this authorization, I understand that I may revoke this authorization at any time, giving written notice to Sarah C. Benoit, LCMHC, LMHC, PLLC. Unless otherwise stipulated, this authorization will expire upon discharge from treatment with Sarah C. Benoit, LCMHC, LMHC, PLLC or on (Insert date of expiration):_____.

I may inspect or copy any information to be used or disclosed under this authorization. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. The information used or disclosed pursuant to the

authorization may be subject to re-disclosure and not longer protected with the exception being information provided regarding HIV/AIDS or substance abuse information.

_____	_____
Signature of Client	Date
_____	_____
Signature of Parent/Legal Representative (if applicable)	Date
_____	_____
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Client
_____	_____
Witness	Date