**RELEASE OF CONFIDENTIAL INFORMATION**

**Nancy H. Sheridan, MSW, LICSW**

35 Center St.

PO Box 915

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603-730-2999

(Fax) 603-569-8925

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, who’s D. O. B. is \_\_\_\_\_\_\_\_,

(Name of client)

Authorize Nancy H. Sheridan, LICSW, to disclose to and/or obtain from:

(Name of person/organization): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone/fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of information to be disclosed:

\_\_\_\_Assessment \_\_\_\_Educational information

\_\_\_\_Diagnosis \_\_\_\_Discharge/Transfer summary

\_\_\_\_Psychosocial Eval. \_\_\_\_Continuing care plan

\_\_\_\_Psychological eval. \_\_\_\_Progress in treatment

\_\_\_\_Psychiatric eval.

\_\_\_\_Treatment plan or summary \_\_\_\_Current treatment plan

\_\_\_\_Medication mgmt. info. \_\_\_\_Attendance/participation in tx.

\_\_\_\_Medical information \_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose**

The purpose of this disclosure of information is to improve assessment and

treatment planning, share information relevant to treatment and when

appropriate, coordinate treatment services. If other/additional information,

describe:

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**Expiration**

Unless revoked sooner, this authorization expires on this date: \_\_\_\_\_\_\_\_\_\_ or as

otherwise indicated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revocation of ROI

I understand that I have a right to revoke this authorization in writing at any time

by mailing written notification to Nancy Sheridan. I understand that a revocation

of the authorization is not effective to the extent that action has been taken in

reliance on the authorization.

**Conditions**

I further understand that Nancy Sheridan will not withhold treatment based on

whether or not I authorize the requested disclosure. However it has been

explained to me that failure to sign this authorization/release of information may

have the following consequences:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Format of disclosure of information**

Unless you have specifically requested in writing that the disclosure be made in a

certain format, I reserve the right to disclose information as permitted by this

authorization in any manner that I deem to be appropriated and consistent with

applicable law including but not limited to verbal, written or electronic form.

**Re-disclosure**

I understand that there is the potential that the protected health information that

is disclosed pursuant to this authorization may be re-disclosed by the recipient

and the protected health information will no longer be protected by the HIPAA

privacy regulations unless state law applies that is more strict than HIPAA and

provides additional privacy protections.

I will be given a copy of this authorization.

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Signature of client Date

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Signature of parent or guardian, if client is a minor. Date

Updated 7/2015