kTherapy / Brainspotting with Katherine
45 Lyme Road, Suite 310A • Hanover, NH 03755 • 833-4-BSPKAT (833-427-7528)

RELEASE OF INFORMATION

Client's Name: ____

Address: ______________________ City: ______________ State: ______ Zip: ________

Phone: ______________________ DOB: ______________________

I, ____ , authorize _kTherapy_ to:

__X_ (send) __X_ (receive) the following __X_ (to) __X_ (from)

Name: ______________________________ Phone: ______________________________

Address: ______________________ City: ______________ State: ______ Zip: ________

Type of information requested:

__X_ Treatment plans
__X_ Progress reports
__X_ Diagnostic Information
____ Discharge Summary
____ *Psychotherapy Notes
____ Other, specify: ____

*A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES.

The above information will be used for the purpose of:________________________________
and will only be exchanged with the individual/agency specified in this document for the period of time that I have authorized.

I understand that the confidentiality of these records is required under the New Hampshire General Statutes N.H. Rev. Stat. Ann. § 135-C:19-a. This information shall not be transmitted by us without written consent or other authorization as provided in the aforementioned statute(s).

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

A facsimile of this Release shall be considered as valid as the original.

Your relationship to client: ____Self ____Parent/legal guardian ____Personal representative
____Other (describe)______________________________

Client's Signature: ______________________________________ Date: ____/____/____

Parent/guardian/personal representative (if applicable)
Signature: ______________________________________ Date: ____/____/____

Witness (if client is unable to sign)
Signature: ______________________________________ Date: ____/____/____