# Comprehensive Counseling Connections, PLLC

## AUTHORIZATION TO OBTAIN AND/OR RELEASE INFORMATION

**Comprehensive Counseling Connections, PLLC is hereby authorized to**

**Obtain_____ Provide_____ Exchange with________**

Name:____________________________________________________________________

Address__________________________________________________________________

Phone Number__________________________Fax Number________________________________

Date(s) of Service(s) Requested: _____________________________________________________

**All Protected Health Information regarding:**

______________________________________________ ____________________

Patients Name Date of Birth

Please check all that apply:

___ALL ___Verbal/Telephone Information ____Progress Notes

___Medical Records ___Psychological/Neurological Testing Records ____Medication List

A copy or facsimile of this authorization shall have the same force as the original. This authorization is valid for one year from the date of signature or until ___________________. I understand I can revoke this release at any time in writing; however, my revocation would not cover action already taken on the basis of this authorization. I further authorize the delivery of this release document to its intended recipient via U.S. Mail or fax.

Signature:__________________________________________________Date:________________________

If parent or legal guardian relation to the child___________________________________

Name of CCC Provider(s):_________________________________________________________________

514 South Street*Bow, NH 03304*(603)-856-8163*Fax (603)-856-8164