Merrimack Adult Day Health Center

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Name of individual: I, (print name of individual or guardian in the case of an incompetent adult),			
i, (print name or individual or)	guardian in t	ne case of an incomp	authorize:
Primary Physician			
Name:			
Agency/Organization:			
Address:			
To Disclose to:			
Name: Merrimack Adult Day Health Address: 32 Daniel Webster Highwa Merrimack, NH 03054			
The following information: (Check as required)x Presence in treatment (verificatex Diagnosisx Physical Examinationx Progress Notesx Treatment/Service Planx Discharge Summary Other (specify)			
For the purposes of: x Treatment/Service Planning x Insurance/Benefit/Funding sou Other (specify)	rce approval		
that my records are protected under	state and federa consent automa	al confidentiality regulatior	re-disclose to any third party. I understand ns. I understand that I may revoke this conser om the date below. I understand that this
Individual Receiving Services	Date	Legal Guardian	Date
Witness	Date	-	