FARNUM
recovery starts here

Release of Information

I, _____ D.O.B.: _____/_____/_____
Client Name

Authorize: _____Easterseals New Hampshire's Farnum Center Substance Abuse Services_____
Name of the Individual or Agency which is to make the Disclosure

☐ To disclose to ☐ To receive from

_____
Name or Title and Address and Phone Number of the Person or Organization to which the Disclosure is to be made

(Please have client INITIAL each box)

☐	Attendance in treatment	☐	Social/Family history
☐	Course and results of treatment	☐	History of psychiatric treatment
☐	Medical Plan/Treatment recommendations/Aftercare	☐	Medical History/treatment
☐	Discharge plans/ Discharge summary	☐	Drug/Alcohol test results
☐	Substance use/abuse history	☐	Biopsychosocial Assessment
☐	Medication history	☐	Chemical dependency evaluations and recommendations
☐	Diagnostic summary and diagnoses	☐	Physical/TB Test
☐	Legal history	☐	Admission Note
☐	Other:	☐	Insurance and/or billing information:
			Contact:

I understand that the information released may include alcohol and substance use disorder information. ____ *(Initials)*

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. ____ *(Initials)*

I understand that patients have the right to receive a list of entities to which their patient-identifying Part 2 information has been disclosed; all requests must be submitted in writing. ____ *(Initials)*

I understand that I can revoke this consent ***in writing*** at any time, except to the extent that the agency, which is to make the disclosure, has already taken action in reliance upon it. If not previously revoked, this consent will terminate upon:

_____One year from date below_____
Specific Date, Event or Condition Upon Which This Consent Expires

I understand that generally my treatment may not be conditioned on whether I sign a consent form and that in certain limited circumstances I may be denied treatment if I do not sign a consent form.____*(Initials)*

I have read this release and understand its contents. ____ *(Initials)*

_____ _____
Client Signature Date

_____ _____
Signature of Parent, Guardian or Authorized Rep. when required Date

_____ _____
Witness Signature Date

A program of easterseals

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Webster Place | 27 Holy Cross Road, Franklin, NH 03235 | phone: 603.934.2020 | fax: 603.934.9815
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