

Release of Information

I, _____ D.O.B. ____/____/____

(Client Name)

Authorize: Easterseals New Hampshire Farnum Center Substance Use Services

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)

<input type="checkbox"/>	Attendance in treatment	<input type="checkbox"/>	Social/Family history
<input type="checkbox"/>	Course and results of treatment	<input type="checkbox"/>	History of psychiatric treatment
<input type="checkbox"/>	Medical Plan/Treatment recommendations/Aftercare	<input type="checkbox"/>	Medical History/treatment
<input type="checkbox"/>	Discharge plans/Discharge summary	<input type="checkbox"/>	Drug/Alcohol test results
<input type="checkbox"/>	Substance use history	<input type="checkbox"/>	Biopsychosocial Assessment
<input type="checkbox"/>	Medication history	<input type="checkbox"/>	Diagnostic screening/evaluation and recommendations
<input type="checkbox"/>	Diagnostic summary and diagnoses	<input type="checkbox"/>	Admission Note
<input type="checkbox"/>	Legal History	<input type="checkbox"/>	Insurance and/or billing information:
<input type="checkbox"/>	Other:	<input type="checkbox"/>	Contact:

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

This information has been disclosed to you from the records protected by federal confidentiality rules (42 CFR Part 2) and the health Insurance Portability and Accountability Act 1996 (HIPPA). 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. ____ (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 understood its contents. ____ (Initials)

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