Date Received:____

Authorization for Use or Disclosure of Information for Purposes Requested by Provider's Office

I, ________________________, DOB___________, hereby authorize ____________________________________
(Patient) (Date of Birth) (Provider)

16 Fifth Street, Dover, NH 03820, Phone#: 603-749-4462, Fax#: 603-749-2475, to:
(Check those that apply)

____ Use/Request the following protected information
____ Disclose the following protected information

(Name of Entity to Receive/Disclose the information)

Name____
Address____
____
Phone#___________________Fax#______________________

(Specifically describe the information to be disclosed, such as psychiatric/psychological evaluations, notes, dates of service, diagnosis, medications, etc.)

____
____

This protected health information is being used or disclosed for the following purpose:

____
____

This information may be disclosed by:

____ Copies ____ Verbal ____ Both ____ Fax

This authorization shall be in force and effect from ____________ to _____________ at which time
(Date) (Date)
this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to __________________ at 16 Fifth Street, Dover, NH 03820. Revocation will be effective as of
(Provider)
the date received. I understand that a revocation is not effective to the extent that __________________has
(Provider)
relied on the use or disclosure of the protected health information prior to the revocation date.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____________________ will not condition my treatment, payment, enrollment in a health plan or eligibility
(Provider)
for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent that the state law provides better access rights).
- Refuse to sign this authorization

____ ___________________
Signature of patient/parent/guardian/legal representative Date

I authorize the release of drug and/or alcohol diagnosis and treatment information.

____ ___________________
Signature of patient/parent/guardian/legal representative Date

TO THE RECEIVING PROVIDER: This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 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 information 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.

I certify that this is a copy of the original Authorization for Release of Information that is in the possession of _______
(Provider)

Signed: ___________________________________ Date: ______________________________
(Office Staff)