Release of Information Authorization

____whose Date of Birth is_____________

Name

____

Name of Person or Title of Person or Organization **phone number**

Description of Information to be Disclosed

Client should initial each item to be disclosed:

______ Assessment	______ Educational Information
______ Diagnosis	______ Toxicological Reports/Drug Screens
______ Substance Abuse Evaluation	______ Discharge/Transfer Summary
______ Psychological Evaluation	______ Other ______________________
______ Psychiatric Evaluation	______ Other ______________________
______ Treatment Plan/Summary	______ Other ______________________
______ Medication and Management of medication	______ Other ______________________
______ Medical Information	______ Other ______________________

Purpose

The purpose of this disclosure of information is to improve assessment and transition planning, share information relevant to treatment when appropriate, and coordinate transition services.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Dismas Home of NH at 102 Fourth Street, Manchester, NH 03102. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization will expire in six months from the date it is signed.

Conditions

I further understand that Dimas Home of NH will not condition my acceptance and services on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences of not being able to provide services being provided.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applied that is more strict than HIPPA and provides additional privacy protections.

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42C.F.R. Part 2.

I have been offered a copy of this authorization for my records.

____

Signature of Applicant/Resident Date

____

Signature of Applicant/Resident Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.)

______Check here if applicant refuses to sign authorization

____

Signature of Staff Witness Date

Rev. 7.25.2018