Dismas Home
NEW HAMPSHIRE

DISMAS HOME OF NEW HAMPSHIRE RELEASE OF INFORMATION

_____whose Date of Birth is _____Telephone #: _____

_____ _____

Name of Person, or Title of Person and/or Organization **Address (include Street, City, Town, and Zip code) Telephone #**

Description of Information to be disclosed: (Client should initial each item to be disclosed):

_____ Assessment
_____ Diagnosis
_____ Substance Abuse Evaluation
_____ Medical Information
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan/Summary
_____ Medication & Management of Medication
_____ Education Information
_____ Toxicological Reports/Drug Screens
_____ Discharge/Transfer Summary
_____ Other _____
_____ Other _____
_____ Other _____
_____ Other _____
_____ 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 of services.

REVOCATION: I understand I have the right to revoke this authorization, in writing, at any time by sending written notification to Dismas Home of New Hampshire at 102 Fourth Street, Manchester, NH 03102. I further understand 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 six months from the date it is signed.

CONDITIONS: I further understand Dismas Home of New Hampshire will not condition my acceptance and services on whether I give authorization for the requested disclosure. However, it has been explained failure to sign this authorization may have the following consequences of not being able to provide services.

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 in any manner we deem appropriate and consistent with applicable law, including but not limited to verbally, paper format or electronically.

REDISCLOSURE: I understand that there is the potential that protected health information 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 is more strict than HIPAA 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 otherwise permitted by 42 CFR Part 2.

_____ _____
Signature of Applicant/Resident Date

Expiration Date of Release (6 months from date of signature):
_____

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 _____
Witness to Signature Date