AUTHORIZATION AND CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION for NON-TREATING PROVIDERS

I, _____ (Name of client), date of birth ___/____/_____ authorize

Treating Provider / Part 2 Program to disclose to and receive from the following non-treating providers:

☐Division of Field Services (Names and titles of PPOs to receive information)
☐Homeless Shelter (Title/Name of Individual)_____
☐Community Action Program (Title/Name of Individual) _____
☐Laconia Fire Department: _____
☐DCYF (caseworker's name)_____
☐Court (Title/Name of Individual)_____
☐Police Department (Title/Name of Individual)_____
☐County Department of Corrections: (Title/Name of Individual(s)_____
☐Other:_____
☐Other:_____

I understand that my medical and behavioral health and substance use disorder treatment records are protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts 160 & 164 and that my substance use disorder treatment records are further protected by the federal regulations governing the Confidentiality of Substance Use Disorder Treatment Records, 42 C.F.R. Part 2and cannot be disclosed without my written consent unless otherwise provided for by the regulations and state law.

The purpose of this consent is to authorize *Name of Treating Provider/Part 2 Program* to disclose and share aspects of my personal healthcare information with the above named non-treating provider and individual(s) in that non-treating provider entity for the purpose of:

☐Monitoring and supporting my ongoing recovery
☐Assessing/evaluating my readiness/ability to participate in housing/employment/vocational training
☐Confirming compliance with court ordered treatment and stipulations of probation or parole
☐To assist DCYF in investigating child abuse or neglect
☐To assist DCYF in monitoring my compliance treatment and with my parenting plan
☐Other:_____
☐Other:_____

Specific information to be disclosed and shared include:
Check all that apply:

Name and other identifying information;
☐Substance use assessments and diagnoses;
☐Mental health assessments and diagnoses;
☐Psychiatric evaluations and diagnoses;
☐Attendance, participation, compliance and progress in substance use disorder treatment;
☐Attendance, participation, compliance and progress in recovery support services;
☐Attendance, participation, compliance and progress in mental health treatment;
☐Substance use disorder history and amounts, frequency and patterns of current use;
☐Substance use disorder treatment plans;
☐Substance use disorder recovery plans;
☐Mental health treatment plans;

☐Medical treatment plans;
☐Discharge plans and recommendations;
☐Family and social history;
☐Emergency room treatment episodes;
☐Hospital admissions;
☐Medical, mental health, and substance use disorder case management, treatment and recovery plans including case management/care coordination activities regarding medical, mental health and substance use disorder treatment, disease management and related psychosocial needs;
☐Medications and medication history
☐Housing needs
☐Legal history, current pending legal charges and convictions, court orders and criminal justice requirements
☐Results of alcohol and other drug screening (urinalysis and breathalyzer);
☐Other:_____

Acknowledgement of Rights

I understand that my substance use disorder treatment records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Treatment Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations and state law. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and if so may not be protected by federal or state law, however federal law prohibits the recipient of information disclosed pursuant to this authorization from making any further disclosure of substance use disorder treatment records without the express written consent of the person to whom it pertains or as otherwise permitted by law.

This consent shall be valid until the time of my death unless such time as my death unless another circumstance is delineated here: until such time as_____ (if filled in), until date listed here_____(if filled in), or until otherwise revoked by me. I understand that I may revoke this consent orally or in writing at any time except to the extent that disclosures have been made in reliance on it.

Upon request, I can inspect or obtain a copy of the information I am authorizing to be released and I can receive a list of all disclosures that have been made, to whom and when they were made.

I understand that I may be denied services if I refuse to consent to a disclosure for the purposes of my treatment, payment or healthcare operations if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I acknowledge that I have been given a copy of this consent form.

_____ _____
Signature of Patient or legal representative or guardian Date

_____
Authority/Relationship of representative to patient
(attach copy of documentation of authority)