Appendix I

WestBridge Community Services
1361 Elm St., Suite 207
Manchester, NH 03101
(603) 634-4446 Fax: (603) 634-4447
Admission Fax: (603) 606-7826

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Participant: ________________________________ Birth date: ____________ Med Rec.#______
Address:____

I authorize WestBridge Community Services to: ______Obtain from ______Release to ______Communicate with:

Name/Facility: ____
Address: ____
Attention: ____ Tel #: ______________________________
Fax #: ______________________________
For treatment date(s)____________________________________to:____

I hereby acknowledge that I fully understand the above statements as they apply to me and that my records cannot be disclosed without my written consent except as otherwise specifically provided by law. I understand that by law, I need not consent to the release of this information, but I choose to do so voluntarily.

Please release the following (check all that apply):
Entire Record _____ Progress Notes____ Admission Note____ Summary____ Treatment Plans____

Physical Exam____ Consults _____ Notice of Admission ____ Lab Reports_____ Psychological tests____

Med Notes_____ Other______________________________________

This information is needed for: Ongoing Tx. _______Aftercare________ Referral _______ Other________

I further release WestBridge Community Services from all legal responsibility or liability that may arise from this disclosure, and I understand that I may revoke my consent at any time, unless action on this release has already begun in good faith.
This authorization expires one year from the date signed, unless otherwise specified here: ________________

_______________________________________ ____________ ________________________
Participant/Guardian Signature Date Relationship to Participant

_______________________________________ ____________
Witness Signature Date

The information to be disclosed includes confidential information as initialed below:
______Psychiatric evaluation/treatment ______HIV test results ______Other

______ Alcohol/Drug Abuse (past or present) ______Communicable Disease

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I hereby revoke this Authorization to Release Medical Information on this date forward:______________________
Date

_______________________________________ ____________________________________
Signature Witness

*NOTE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

FILE: Release of Information Section