WestBridge

660 Chestnut Street, Manchester, NH 03104
Phone: (603) 634-4446 **Medical Records & Admissions Fax**: (603) 606-7826

Authorization to Disclose/Obtain Protected Health Information

Participant Name: _____ **Date of Birth:** _____

WestBridge abides by all federal and state confidentiality laws including the Health Insurance Portability & Accountability Act (HIPAA) and 42 CFR Part 2. I understand there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient in violation of the HIPAA privacy regulation. By signing this authorization, I acknowledge, accept and agree with this statement.

I hereby authorize WestBridge to ☐**disclose/release to** and/or ☐**obtain the following information from:**

_____ _____
Name **Relationship to Participant**

_____ _____ _____
Address **Telephone number** **Fax Number**

Information to be Disclosed: From Date: _____ To Date: _____

Participant will check off and initial each item to be disclosed

☐____ Presence/Participation in Treatment
☐____ Demographic Information
☐____ Intake Information
☐____ Diagnosis
☐____ Mental Health Disorder Information
☐____ Treatment Plan or Summary
☐____ Integrated Clinical Summary
☐____ Psychiatric Evaluation
☐____ Medication Information
☐____ Nursing/Medical Information
☐____ Toxicological Reports/Drug Screens
☐____ LAB/Medical Tests ordered by WestBridge
☐____ Progress Notes
☐____ Therapy Notes
☐____ Current Treatment Update
☐____ Discharge/Transfer Summary
☐____ Billing Information
☐____ Other _____

Substance Use Disorder Information[1]
(protected pursuant to 42 CFR Part 2)

☐____ I authorize the release of information relating to referral and/or treatment for alcohol and drug use
☐____ I **prohibit** the release of information relating to referral and/or treatment for alcohol and drug use

HIV/AIDS/STD/Communicable Disease Information
(protected pursuant to RSA 141-C and F)

☐____ I authorize the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease
☐____ I prohibit the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease

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

Revocation: I understand that I have a right to revoke this authorization, in writing by signing the below revocation. I further understand that revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

☐____ In the event of revocation, I grant WestBridge permission to notify the above named individual/entity of the revocation only.

Expiration: This authorization expires one year from date signed, unless otherwise specified here: _____

Conditions: I understand that WestBridge will not condition my treatment 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 ongoing treatment and or 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 the authorization in any manner we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

[1]**Recipient Disclaimer**: This information has been disclosed to you from records in which confidentiality is protected by federal law. 42 CFR Part 2 prohibits the recipient from making any further disclosure of it without the specific written consent of the person whom it pertains or except as otherwise permitted by substance use disorder regulations. A general authorization for the release of medical or other information is *not* sufficient for this purpose. Information disclosed under 42 CFR Part 2 cannot be used to criminally investigate or prosecute any participant with a substance use disorder except as provided for in 42 CFR Part 2.

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

_____ _____ _____
Participant/Guardian Signature Printed Name Date

_____ _____
Witness Signature Date

FOR REVOCATION ONLY

I hereby revoke this Authorization to Disclose/Obtain Protected Health Information on this **date and time** forward:

_____ **Date:** _____ **Time:** _____ **am/pm**
Participant/Guardian Signature