



GREATER NASHUA COUNCIL
ON ALCOHOLISM, INC.

615 Amherst Street, Nashua, NH 03063

Tel: 603-881-4848, Fax: 603 598-3644

Release of Information Authorization

_____ whose Date of Birth is _____,
Name

authorize Greater Nashua Council on Alcoholism (GNCA)/Keystone Hall to **disclose to** and/or **receive from** the following::

Name of Person or Organization: _____ Phone Number: _____

Designation of Person/Entity to Whom Information is to be Released: _____

Description of Information to be Disclosed/Received:

Client *MUST initial* each item to be disclosed and/or received:

- | | |
|--|---|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Educational Information |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Toxicological Reports/Drug Screens |
| <input type="checkbox"/> Substance Use Disorder Evaluation | <input type="checkbox"/> Discharge/Transfer Summary |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Continuing Care Plan |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Progress in Treatment |
| <input type="checkbox"/> Treatment Plan or Summary | <input type="checkbox"/> Demographic Information |
| <input type="checkbox"/> Current Treatment Update | <input type="checkbox"/> Psychotherapy Notes* |
| <input type="checkbox"/> Medication Management Information | (*Cannot be combined with any other disclosure) |
| <input type="checkbox"/> Presence/Participation in Treatment | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Nursing/Medical Information | <input type="checkbox"/> Other _____ |

Describe the Purpose: _____

Revocation

I understand that I have a right to revoke this authorization, in writing, with the exception of Part 2 (substance use disorder treatment) information which may be released verbally, at any time by sending written notification to GNCA/Keystone Hall at 615 Amherst Street, Nashua, NH 03063 or by calling Keystone Hall at 881-4848. 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.

Conditions

I understand that GNCA/Keystone Hall will not condition my treatment based on a signed release, however, I understand that I may be denied services if I refuse to consent to a disclosure for the purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to sign a consent form for a disclosure for other purposes.

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.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that 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 use disorder treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

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

Signature of Client Date

Signature of Parent, Guardian or Personal Representative 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 patient/client refuses to sign authorization

Signature of Staff Witness Date