KEYSTONE HALL
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:

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

This release of information authorization expires one year from date signed unless otherwise noted.
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