

Patient Registration and Consent for Treatment

All New Patient forms: FAX to 603-692-1070

Services Interested in: Suboxone Treatment IOP Vivitrol

Name (First, MI, Last): _____ Gender: Male Female
 Date of Birth: ____/____/____ Marital Status: Single Married Social Security #: _____ - _____ - _____
 Mailing Address: _____ City/State: _____ Zip Code: _____
 Street Address: _____ City/State: _____ Zip Code: _____
 Phone (Home): _____ Phone (Cell): _____ Phone (Work): _____
 Email: _____ Primary Care Provider: _____ Referring Provider: _____

*We may wish to communicate upcoming appointment information, test results and/or other information regarding your medical care. What is the best phone number for contact where we may also leave messages? Home Cell Work

Emergency Contact: _____

Relationship: _____ Phone: _____

- Can the above listed contact (with photo identification) pick up prescriptions if you are unavailable? Yes No
- If you would like to give us permission to discuss personal information in your medical record with someone other than yourself, please fill out the **Permission to Discuss Form**.

Race

- White
 Black or African American
 Asian
 Other: _____
 American Indian or Alaska Native
 Native Hawaiian or Other Pacific Islander

Preferred Language

- English
 Other: _____

Ethnicity

- Non-Hispanic or Latino
 Hispanic or Latino
 Other

Insurance Information* (please present card for copying)

Primary Insurance: _____
 Insurer ID#: _____
 Group #: _____
 Claims Address: _____
 Subscriber: _____
 Subscriber's Date of Birth: _____
 Relationship to patient:
 Self Spouse Other

Secondary Insurance: _____
 Insurer ID#: _____
 Group #: _____
 Claims Address: _____
 Subscriber: _____
 Subscriber's Date of Birth: _____
 Relationship to patient:
 Self Spouse Other

- The above information is thorough and accurate to the best of my knowledge. For any changes to the above information, I will notify the office.
- I consent to evaluation and treatment by any provider at ROAD to a Better Life. I hereby authorize release of medical information that is necessary for my further treatment.

 Patient Signature (or Guardian)

 Date

CPS Update/Staff Initial

**Financial Policy and Consent for Billing
Consent for Treatment
Receipt of Documents**

Payment Policy:

We ask that you read through the financial policy and sign the bottom prior to treatment. Co-pays are due at the time of service, or full payment is due for self-pay patients unless prior arrangements have been made with our billing department. We accept cash or credit cards (Visa, MasterCard and Discover). On a limited basis checks may be accepted and there is a service charge on any returned check; payment in full will be required within 10 days of notice.

Insurance:

Our office will kindly bill your insurance company. We participate with a number of medical insurance plans that we will contact to verify eligibility and benefits. Please realize that you have the **ultimate responsibility of verifying the coverage with your insurance.** You acknowledge that we may be an out of network provider with your insurance. You are also aware that in some circumstances your insurer will send payment directly to you. You agree to endorse the insurance check and forward funds to the appropriate entity above within 30 days of receipt. You will be responsible for any balance not paid or denied by your insurance carrier. Patients who do not supply accurate insurance information will be considered self-pay. You must inform our office of any changes in your insurance, as you are the policyholder and it is your responsibility.

Insurance Referrals:

If your plan requires a referral from your Primary Care provider, it is your responsibility to obtain it before seeking treatment from us. If a claim is denied due to a lack of referral you will be responsible for charges. You understand that you are financially responsible for claims denied or not covered by your insurance carrier for failure to obtain a referral.

Missed Appointments:

If you are unable to keep your appointment you must notify the office at least 24 hours prior to your scheduled appointment as courtesy to the doctors, staff and other patients. If you cancel or "no-show" without sufficient notice, you may be subject to a fee, payable by you, not your insurance company.

Please let us know if you have any questions regarding our Financial Policy.

I consent to evaluation and treatment by any provider at ROAD. I hereby authorize release of medical information that is necessary for my further treatment.

I have read and agree to the terms of the above information. I understand payment is expected at the time services are rendered and that I am responsible for any balance.

I, the undersigned, hereby authorize and direct my insurance carrier to pay benefits for services rendered, directly to PMC Medical Group, LLC or any of its affiliates.

Patient Name (Please print): _____ **DOB** _____

Signature of Patient (or Legal Representative): _____ **Date:** _____

_____ **Patient: *Complete Receipt of Documents below at the ROAD Office*** _____

Receipt of Documents

I have received and understand the information contained in the following documents:

1. Notice of Privacy Policies
2. Patient Bill of Rights & Responsibilities
3. Patient Bill of Rights ~ Mental Health
4. Patient Complaint Procedure
5. Advance Directives Information
6. Alcohol & Drug Confidentiality Notice

Signature of Patient (or Legal Representative): _____ **Date:** _____

Health History Form
Name: _____

Date of Birth: ____/____/____

Reason for today's visit: _____

CURRENT MEDICATIONS

Name of Medication	Strength (ex. 500 mg)	Dosing Instructions (ex. Twice a day)

ALLERGY HISTORY
 No Known Allergies
 Medication Allergies
 Environmental/Seasonal Allergies
 Latex Allergies

Allergen (ex. Food, Dust, Animals, Pollen, Medication)	Reaction (ex. Rash, nausea, respiratory, shock, etc.)

SOCIAL HISTORY (Please circle all applicable responses)

Marital Status	Single	Significant Other	Married	Divorced	Widowed			
Sexual Orientation	Heterosexual	Gay	Lesbian	Bisexual	Transgender			
Living Situation	Alone	Spouse/Significant other	Children/Family	Other:				
Homeless	Residential							
Females- Are you pregnant?	Yes / No	Hysterectomy	Menopause	Tubal ligation				
What are your hobbies?								
Education (highest level)	9	10	11	12	Some college	Associates	Bachelors	
	GED			Masters	PhD			
Employment?	Full-time	Part-time	Unemployed	Seeking employment	Disabled	Retired		
If yes, Employer:	Occupation:			# of Years:				
Previous work experience?	Yes / No	If yes, description:						
Military History	None / Past / Current		Army	Navy	Marines	Coast Guard	National Guard	
Combat?	Yes / No	If yes, Where:						
Discharge?	Yes / No	If yes:	Honorable	General	Dishonorable	Retired	Other	
VA Disability?	Yes / No	If yes, due to:						
Spiritual/ Religious Affiliation?	Yes / No	Practicing/ Role of Faith Past & Present?						
Receiving Benefits?	Yes / No	APTD	SSI	SSDI	Food Stamps	Fuel Asst.	Section 8	Disability
		Public/HUD Housing	PASS Plan	Workers comp	Unemployment			

If applicable, amount?

Tobacco Use?	Yes / No	Cigarettes / Cigars / Chew	Per day:
<i>If no, have you ever?</i>	Yes / No	Cigarettes / Cigars / Chew	Per day:
Do you drink alcohol?	Yes / No	Beer / Wine / Liquor	Per day:
Do you drink caffeine?	Yes / No	Coffee / Tea / Soda / Energy Drink	Per day:
Do you exercise?	Yes / No	Type?	
Do you wear your seatbelt?	Yes / No	If yes, percent of time:	

MEDICAL HISTORY (Please check any of the following that you have or have had in the past)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Acid Reflux/GERD | <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Dementia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Glaucoma/Cataracts | <input type="checkbox"/> Immune Disorders | |

- Are you/do you have: Obsessive compulsive? _____ Eating disorder? _____ Panic Attacks? _____
- Have you participated in high-risk sexual practices? _____ If so, please describe: _____
- Have you had Hepatitis? Yes No Venereal Disease? Yes No Last HIV test _____
Results? _____
- Do you now have, or have you ever had, seizures or convulsions? Yes No
If yes, when, and what condition caused them? _____ When was the last seizure or convulsion? _____

For Women Only:

At what age did you start to menstruate? _____

 Do you now have, or have you had, any problems with your menstrual period? Yes No

If yes, please describe these problems: _____

Have you had any:

 Pregnancies? Yes No If yes, how many? _____ When? _____ Were you using? _____

 Miscarriages? Yes No If yes, how many? _____ When? _____ Were you using? _____

 Abortions? Yes No If yes, how many? _____ When? _____ Were you using? _____

Menopausal symptoms or treatment? If yes, when? _____

For Men Only:

Do you now have, or have you had, problems with your prostate, difficult or painful urination, or impotence?

 Yes No If yes, please describe those problems: _____

FAMILY HISTORY (Please tell us about your immediate family)

CHILDREN None

First Name	Last Name	Age	Living With?	Custody?	Quality of Relationship
			Yes / No	Yes / No	
			Yes / No	Yes / No	
			Yes / No	Yes / No	
			Yes / No	Yes / No	

SPOUSE/SIGNIFICANT OTHER None

Name	Age	Occupation	Quality of Relationship

Relationship	Age	Marital Status	Occupation	Living with?	Quality of Relationship
Mother				Yes / No	
Father				Yes / No	
Sibling:				Yes / No	
Sibling:				Yes / No	
Sibling:				Yes / No	
Other:				Yes / No	
Place of Birth:			Place of upbringing:		
Family is:	Intact	Parents Separated/Divorced		Parents Remarried	
Resided with:	Mother	Father	Adopted	Orphaned	Other:

<i>Health History</i>	Father	Mother	Siblings	Children	Other
Age at Death					
Cause of Death					
Heart Disease/ Stroke					
High Blood Pressure					
Diabetes					
Cancer (type)					
Epilepsy					
Asthma					
Blood Disease					
Other:					

Contact with Family (check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Visit at least monthly | <input type="checkbox"/> Involved with treatment providers | <input type="checkbox"/> Family is available locally |
| <input type="checkbox"/> Supportive | <input type="checkbox"/> Knowledgeable about mental illness | <input type="checkbox"/> Family members not available |
| <input type="checkbox"/> Non-supportive | <input type="checkbox"/> Involved in NAMI or other support group | <input type="checkbox"/> Satisfied with family/relationship contact |
| <input type="checkbox"/> Not satisfied with family relationship/contact | | |

SUBSTANCE ABUSE HISTORY
Family Substance Abuse (Please check any family that apply, and list substance abused)

-
- None
-
- Parents: _____
-
- Siblings: _____
-
- Extended Family: _____

Do you or your family think you have a problem with:

- | | | |
|---|--|--|
| Shopping? Yes <input type="checkbox"/> No <input type="checkbox"/> | Barbiturates? Yes <input type="checkbox"/> No <input type="checkbox"/> | Internet? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Sex Addiction? Yes <input type="checkbox"/> No <input type="checkbox"/> | Gambling? Yes <input type="checkbox"/> No <input type="checkbox"/> | |

 Have you had any previous rehab or **treatment of substance abuse?** Yes No

Where?	Reason there?	How Long?	In patient/ Outpatient?	Date

(Please indicate which of the following drugs you have used, if any)

Substance	Age at first use	How often you use	How much you use	Method (s) you use	How long since last use
Alcohol					
Methamphetamine					
Amphetamine					
Barbiturates					
Cocaine (powder)					
Cocaine (crack)					
Hallucinogens					
Heroin					
Methadone					
Morphine					
Opium					
Inhalants					
Marijuana/Hashish					
PCP (Angel Dust)					
Ketamine (Special K)					
Ecstasy (x)					
Other: _____					

Did/do you go to "meetings?" _____ Do you have a sponsor? _____

Do you see a psychiatrist and if so who and how long? _____

Do you see a therapist or counselor and if so who and how long? _____

Have you ever been treated for depression if so when? _____

LEGAL HISTORY (Please report any and all legal issues)

Legal or Criminal Involvement?	Yes / No	<i>Court order</i>	<i>Probation</i>	<i>Parole</i>	<i>Restraining Order</i>
<i>Found not competent to stand trial</i>		<i>Homicide or attempted homicide</i>		<i>Sexual Assault</i>	<i>Arson</i>
				<i>Assault</i>	<i>Felony</i>
Probation/Parole Officer	Current / Past	Name:		County:	
DUI (date):	Warrants (date):			Violent Crime (date):	
Incarceration, date(s):		How long:		Reason:	
Do you have firearms at home?	Yes / No	<i>If yes, Are they locked?</i>		Yes / No	

MENTAL HEALTH
Stressful events over the last year:

- | | | |
|---|--|--|
| <input type="checkbox"/> Recent Hospital Discharge | <input type="checkbox"/> Access to Healthcare | <input type="checkbox"/> Financial Problems |
| <input type="checkbox"/> Death/ Divorce/ Separation | <input type="checkbox"/> Witness/Victim of Violence | <input type="checkbox"/> Legal Problems |
| <input type="checkbox"/> Relationship problems | <input type="checkbox"/> History/Current Abuse | <input type="checkbox"/> Social/Environmental Problems |
| <input type="checkbox"/> Move | <input type="checkbox"/> Disability (self or family) | <input type="checkbox"/> Other Family Problems |
| <input type="checkbox"/> Educational Problems | <input type="checkbox"/> Parenting Issues | <input type="checkbox"/> Health Problem: _____ |
| <input type="checkbox"/> Housing Problems | <input type="checkbox"/> Job Loss | <input type="checkbox"/> Other: _____ |

Please check symptoms experienced in the last 4 weeks:

MOOD <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Hopelessness	<input type="checkbox"/> Mood Changes <input type="checkbox"/> Sadness <input type="checkbox"/> Elation (happier than normal) <input type="checkbox"/> Anger/Rage	<input type="checkbox"/> Overwhelming guilt/shame <input type="checkbox"/> Difficulty enjoying life <input type="checkbox"/> Irritability
BEHAVIORS <input type="checkbox"/> Hurting yourself <input type="checkbox"/> Doing the same thing repeatedly	<input type="checkbox"/> Uncontrolled spending/gambling <input type="checkbox"/> Increased alcohol/drug use	<input type="checkbox"/> Reckless behavior <input type="checkbox"/> Social Isolation
PHYSICAL <input type="checkbox"/> Increased Sleep <input type="checkbox"/> Decreased Sleep <input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Panic/ Anxiety Attacks <input type="checkbox"/> Increased Appetite/ weight gain <input type="checkbox"/> Decreased Appetite/ weight loss <input type="checkbox"/> Disturbing nightmares/dreams	<input type="checkbox"/> Agitation/Restless <input type="checkbox"/> Unusual sensory experience (smell, taste) <input type="checkbox"/> Other (specify):
THINKING <input type="checkbox"/> Wanting to take your life <input type="checkbox"/> Wanting to hurt someone else <input type="checkbox"/> Seeing/Hearing things that aren't there <input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Intrusive negative thoughts <input type="checkbox"/> Flashbacks <input type="checkbox"/> Irrational fear <input type="checkbox"/> Racing thoughts <input type="checkbox"/> Paranoia	<input type="checkbox"/> Low self-esteem <input type="checkbox"/> Academic/work problems <input type="checkbox"/> Easily distracted <input type="checkbox"/> Thinking same thought repeatedly <input type="checkbox"/> Memory problems
INTERPERSONAL <input type="checkbox"/> Increased conflict w/ others <input type="checkbox"/> Increased family conflict <input type="checkbox"/> Difficulty making/keeping friends	<input type="checkbox"/> Socially withdrawn/isolation <input type="checkbox"/> Increased sexual problems/concerns <input type="checkbox"/> Increased social anxiety <input type="checkbox"/> Problems with intimacy	<input type="checkbox"/> Increased difficulty tolerating others <input type="checkbox"/> Trouble with law/authority figures <input type="checkbox"/> Intermittent relationships

TREATMENT QUESTIONNAIRE

 Have you had any previous **psychiatric hospitalizations**? Yes No

Where	When	Reason

 Have you had any previous **outpatient mental health treatment**? Yes No

Where	When	Reason

 Have you had any previous **prescribed psychiatric medications**? Yes No

Medication	Prescribing Doctor	Dates

 Have any family members had a history of **mental illness**? Yes No

Persons	Diagnosis or Symptoms	Treatments

Have you ever experienced any **trauma**? Yes No

If yes, have you been: Neglected Physically Abused
 Emotionally Abused Sexually Abused Don't Know

Any other incidents of **trauma**: Acts of War Witness/Victim of violence
 Serious Accidents Fire Other

Describe:

How are you **sleeping**? (Describe any recent changes or problems)

How is your **appetite**? (Include any recent weight changes)

What **leisure or stress reduction activities** do you use?

Past **interests/activities**:

Do symptoms interfere with your ability to work or get things done? Yes No

Additional Comments/Information:

The above information is thorough and accurate to the best of my knowledge.

Patient Signature (or Guardian)

Date

**Informed Consent and Treatment Agreement
for Subutex®/Suboxone® (Buprenorphine)**

Name of Patient _____

Date of Birth: _____

Please initial all items

1. I understand the frequency of visits will be weekly at first and then biweekly. As my recovery progresses, with the completion of group therapy and maintenance of personal psychotherapy, my visits may extend out to 4 weeks. I understand that if I relapse or miss appointments then I will return to weekly visits until assurance in my recovery is reestablished. I must call 24 hours prior to canceling an appointment. If I miss an appointment without contacting my provider: I may be asked to return to more frequent visits, I may not have my medication refilled until I am seen again, and I may be discharged.
2. I understand that if I am not seen in the office as prescribed by my provider, I will be unable to obtain my prescriptions and I will be discharged from the ROAD program.
3. I agree to take Buprenorphine as prescribed/directed at the dosage determined by my providers; and not to allow anyone else to take medications prescribed for me.
4. **I am required** to participate in therapy in a group and/or individual setting. When therapy is offered at the location of my ROAD provider, I **am required** to attend group/individual therapy at that location. I also understand that **I am required** to attend AA/NA meetings. (Verification of attendance required for AA/NA and for therapy conducted at 'non-ROAD' locations.)
5. I agree not to take any other medications with Buprenorphine without prior permission from my provider. I understand that overdose deaths have occurred when patients have taken other medications (particularly medications like **Librium®**, **Valium®**, **Xanax®**, **Klonopin®** or other benzodiazepines) with Buprenorphine.
6. I understand that combining illegal substances with prescribed medication increases my risk of breathing difficulties, heart disorders, and sudden death. If I do so, I may be discharged from the practice.
7. I understand that the Buprenorphine providers **will not be available** to prescribe medication during evenings, weekends, or after 12 noon on Fridays. It is my responsibility to **call my provider at least 2(two) business days in advance** of running out of medications.
8. It has been explained to me and I understand that Buprenorphine itself is an opiate drug, although a partial agonist, it can still produce physical dependency in non-opiate dependent patients.
9. The goal of treatment of opiate dependency is to learn to live without abusing drugs. Buprenorphine treatment should continue as long as necessary to prevent relapse to opiate abuse/dependence and then be weaned off.
10. If I have been on Methadone maintenance, I agree that my provider can coordinate my medication switch with the provider of Methadone. This may involve exchange of medical records and discussions with the Methadone clinic, physician or staff. **After switching to Buprenorphine, I will not take Methadone.**
11. I will submit my own urine specimen for drug screen (narcotic, pot, cocaine, amphetamine, PCP, alcohol, benzodiazepine, and others) upon my provider's request as often as directed. My Buprenorphine provider may ask that a clinical staff member observe me providing the appropriate specimen. If my drug screen indicates the presence of illegal/inappropriate substances, or has no buprenorphine or buprenorphine metabolites, I will be discharged.
12. I understand that I will be required at any time with short notice to bring in my medication for inspection and counting. If I do not show or have the appropriate amount of medication, I may be discharged. I may never dispose of medication myself without a staff member as a witness.

- 13. I understand that I must call **at least 24 hours** prior to any appointment if I need to cancel. If I do not come for my appointment or I fail to provide sufficient notice, I am subject to a 'no show' cash fee.
- 14. I allow my provider to communicate with other providers regarding my medical care, consistent with HIPAA guidelines. Treatment disclosure may include, but is not limited to, discussing my medications with the pharmacist. I understand that records released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may contain confidential information about communicable diseases including HIV (AIDS) or related illnesses.
- 15. I will not sell, share, or trade my medication with anyone. It is understood that if caught doing so, I will be discharged without the chance to be readmitted.
- 16. **I will safeguard my written prescription** and medication from loss, damage or theft. We recommend a lock box especially for those with children. Lost, stolen or damaged prescriptions/medications may be replaced at the provider's discretion. If replaced, no prior authorization will be completed and you will be responsible for any prescription costs in such cases.
- 17. I will never alter a prescription in ANY way. I understand this is a felony, punishable by incarceration.
- 18. I authorize the Buprenorphine provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including New Hampshire's Board of Pharmacy and the DEA, in the investigation of any possible misuse, prescription forgery, sale or any other diversion of my medication.
- 19. I allow my Buprenorphine provider to receive information from any pharmacy I have used.
- 20. I will have all my medications filled only at the pharmacy I have listed below. I will inform my Buprenorphine provider of any pharmacy changes
- 21. I understand that rude or disrespectful treatment of staff is not tolerated and may result in my discharge. (Ex: using profanity, raising my voice, making vulgar or inappropriate comments)
- 22. [For women of childbearing potential] I agree to tell my physician if I become pregnant or even think I may be pregnant.
- 23. I understand that I must provide a viable contact number at all times (and will update the office of any changes) or my provider may not prescribe medications.
- 24. I understand the commitment to the program and the many appointments, therefore transportation cannot be an issue or a reason for short notice cancelations or no show appointments.
- 25. I understand that my prescription will need to be filled immediately following my appointment while our staff is still available to take care of any questions or issues at the pharmacy.

I have read and understand the above details about buprenorphine treatment and I wish to be treated with buprenorphine.

I have been given the opportunity to have any questions addressed regarding the above.

Name _____

Pharmacy _____ Town _____ Phone _____

Primary Care Provider _____ Town _____ Phone _____

Signature _____ Date _____

2 copies given to patient
Two copies of this form are to be given to the patient after they sign; one for their records and one for the Pharmacy's records.



Road to a Better Life
 Main Office: 255 Route 108, Somersworth, NH 03878
 Ph: 603.841.2300 Fax: 603.692.1087
 RoadtoabetterlifeNH.com

Protected Health Information (PHI) Release Authorization - **Criminal Justice**

Applies only to: Disclosures to elements of the criminal justice system which have referred patients for participations in a Partial Use Disorder Program (SUDP) as a condition of the disposition of any criminal proceedings against the patient or of the patient's parole or other release from custody. Information related to criminal justice system duty to monitor patient progress (prosecuting attorney, court, probation, parole, DCYF.)

Name (First, MI, Last) _____ DOB ____ - ____ - ____

Mailing Address _____ City/State/Zip _____

Phone Number (H) _____ (C) _____ (W) _____

I hereby authorize ROAD to disclose my Protected Health information as follows:

Specific REASON for Release: Criminal Justice System _____

Disclosure is made only to those individuals within the criminal justice system who have need for the information in connection with their duty to monitor the patients progress (e.g. a prosecuting attorney who is withholding charges against the patient, a court, probation officer, parole officer, or parole officer responsible for supervision of the patient) AND the patient has signed a written consent to release.

Specify Release to WHO: Facility & Person: _____

Address _____ Phone: _____ Fax: _____

Specify DURATION of Release Consent: DATES OF SERVICES from _____ to _____

(Duration: anticipated length of treatment, type of criminal proceeding, expected final disposition)

Specify RECORDS to be released: Mark or describe

Specify Items (may include information related to Mental Health Psychotherapy, Drug/Alcohol, Genetic Testing, HIV/AIDS External Records)

____ Office Visit Notes ____ Lab Results ____ Imaging Reports ____ Procedure/Surgery Notes

____ Consultations ____ Test Results ____ Medications/Pharmacy ____ Billing Reports

____ HIV/AIDS ____ Alcohol/Drug/Substance Abuse ____ Genetic Testing ____ Mental Health

____ Entire medical record (includes Mental Health Psychotherapy, Alcohol/Drug/Substance Abuse, Genetic, HIV/AIDS, & External Records)

____ Other: _____

I, the Patient, OR Authorized Person of Patient, UNDERSTAND :

- I understand that this consent is revocable upon the passage of the specified time or the occurrence of a specified event. This consent becomes revocable no later than the final disposition of the conditional release or other actions in connection with which this consent is given, except where a disclosure has already been made in reliance on my prior authorization).
- I may choose to refuse to sign this form.
- I have the right to inspect or copy the information I am consenting to release, in accordance with the organization's established policies.
- My right to healthcare treatment is not conditioned on this authorization.
- I understand that disclosure of this information carries with it the potential for disclosure and the information may not be protected by federal/state confidentiality rules.
- There may be a charge for the requested records
- Unless otherwise specified, release may be in any reasonable manner including: verbal, paper, typed fax, or electronic.

PATIENT/Authorized Person SIGNATURE: _____ Date: _____

Authorized Person NAME (print) _____ Relationship: _____

Substance Abuse Disorder treatment information (covered by 42 CFR Part 2.35): Notice to recipient of protected information: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2.35). The federal rules state that a person who receives patient information relative to this consent may disclose and use it only to carry out person's official duties with regard to the patient's conditional release or other action in connection with which the consent is given.

The federal rules prohibit you from making any further disclosure of information in this record file to a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of a source by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder as provided at §§ 2.12(c)(5) and 2.65.



Road to a Better Life
Main Office: 255 Route 108, Somersworth, NH 03878
Ph: 603.841.2301 Fax: 603.692.1081
RoadtoabetterlifeNH.com

Protected Health Information (PHI) Release Authorization

Name (First, MI, Last) _____ DOB ____ - ____ - ____

Mailing Address _____ City/State/Zip _____

Phone Number (H) _____ (C) _____ (W) _____

I hereby authorize disclosure of my Protected Health information as follows:

Specify REASON for Release: ___ Transfer of Care ___ Ongoing Care/Specialist ___ Legal ___ Personal
___ Billing/Insurance ___ Other: _____

Specify WHO: Obtain FROM: ___ Our Organization Release TO: ___ Our Organization

Facility & Person: _____ Facility & Person: _____

Address: _____ Address: _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

Specify DATES & RECORDS to be released: Mark or describe

Specify Dates of Service: from _____ to _____

Specify Items (may include information related to Mental Health/Psychotherapy, Drug/Alcohol, Genetic Testing, HIV/AIDS, & External Records)

- Office Visit Notes Lab Results Imaging Reports Procedure/Surgery Notes
Consultations Test Results Medications/Pharmacy Billing Reports
HIV/AIDS Alcohol/Drug/Substance Abuse Genetic Testing Mental Health
Entire medical record (includes Mental Health/Psychotherapy, Alcohol/Drug/Substance, Genetic, HIV/AIDS, & External Records)
Other: _____

I, the Patient, OR Authorized Person of Patient, UNDERSTAND:

- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
I may choose to refuse to sign this form.
I have the right to inspect or copy the information I am consenting to release within the organization's established policies.
My right to healthcare treatment is not conditioned on this authorization.
I understand that disclosure of this information carries with it the potential for re-disclosure and the information may not be protected by federal/state confidentiality rules.
There may be a charge for the requested records.
This release will expire 12 months after date of signature unless date is specified: _____
Unless otherwise specified, release may be in any reasonable manner including: verbal, paper, unencrypted fax/electronic.

PATIENT/Authorized Person SIGNATURE: _____ Date: _____

Authorized Person NAME (print): _____ Relationship: _____

Substance Abuse Disorder treatment information (covered by 42 CFR Part 2): Notice to recipient of protected information: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.