Road to a Better Life
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RoadtoabetterlifeNH.com

Protected Health Information (PHI) Release Authorization

Name (First, MI, Last)_____DOB _____-_____-_____

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

Release FROM: ROAD or Specify:	**Release TO:** ROAD or Specify:
Facility & Person:_____	Facility & Person:_____
Address: _____	Address: _____
_____	_____
Phone: _____ Fax: _____	Phone: _____ Fax: _____

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

Specify DATES to be released: Mark or describe
Limited From _____ to _____ **Unlimited** _____ (First visit through expiration of this release)
Limited From _____ to: Ongoing to expiration of this release

Specify RECORDS to be released: Mark or describe

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

____Office Visit Notes (may include Mental Health, Drug/Alcohol, Genetic Testing, HIV/AIDS, & External Records)

____Procedure/Surgery Notes ____Lab Results ____Imaging Reports ____Alcohol/Drug/Substance Abuse

____HIV/AIDS ____Genetic Testing ____Mental Health ____Medications/Pharmacy ____Billing Reports

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

____ Other: _____

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

- This release will expire 12 months after date of signature unless date is specified: _____
- 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.
- Unless otherwise specified, release may be in any reasonable manner including: paper, unencrypted fax/electronic.

PATIENT/Authorized Person SIGNATURE: _____ Date: _____

Authorized Person NAME (print)**: _____ Relationship: _____**

For Substance Abuse Disorder Program 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.