Antrim House
55 Main Street, Antrim, NH 03440 | (603) 808-0185
Sobriety Centers of New Hampshire | Outpatient Program
info@sobrietycentersofnh.com

Permission to Discuss

Name (First, MI, Last)____

Mailing Address_____________________________**Town/City/Zip**________________________________

Phone Number (H)___________________________**(C)**______________________**(W)**_________________

I ____ give permission to Sobriety Centers of New Hampshire to discuss/release the following medical information about me.

(Check all that apply):

- ☐ Medical information, including but not limited to, my symptoms, diagnosis, medications, and treatment plan.
- ☐ Behavioral Health information, including but not limited to, my symptoms, diagnosis, medications, and treatment plan.
- ☐ Chemical Dependency information, including but not limited to, my symptoms, diagnosis, medications, and treatment plan.
- ☐ Lab, X-Ray/other test results.
- ☐ Only medical information related to: ____
- ☐ Billing Questions (Balances, Insurance Issues, and Copies of Bills)
- ☐ Other (be specific): ____

Sobriety Centers of New Hampshire has my Permission to discuss/release the above information with: (spouse, parent, probation officer, lawyer)

Name: ___________________________________	Name:___________________________________
Address: _________________________________	Address: _______________________________
City, State, Zip: ___________________________	City, State, Zip: _________________________
Relationship: ______________________________	Relationship: ____________________________

Medical records are defined as: All health information, whether oral or recorded in any form or medium that identifies the patient or can readily be associated with the patient and relates to the patient's care. This includes all health care information in you/our possession, whether generated by you/us or any other source, as well as health care information associated with drug/alcohol abuse, mental or psychiatric care, abortion, and HIV status and/or diagnosis of AIDS and/or other sexually transmitted diseases including hepatitis, unless restricted above.

I understand that this authorization may be revoked by me at any time, provided that I do so in writing and submit it to the Medical Records Department, up to the extent that the disclosure has not already been made. I also understand that my protected health information may be re-disclosed by the recipient and no longer protected under federal law.

____ **Date:** __________________

Signature of Patient or Legal Representative

Witness ____ **Date:** __________________