Sobriety Centers of New Hampshire

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

Protected Health Information (PHI) Release Authorization - Criminal Justice

Applies to: information related to criminal justice system duty to monitor patient progress (prosecuting attorney, court, probation, parole.

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

Mailing Address_____**Town/City/Zip**_____

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

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

Duration of consent: DATES OF SERVICES from _____ to _____.
(Duration: anticipated length of treatment, type of criminal proceeding, expected final disposition.)

TYPE OF RECORDS REQUESTED: (please check your request)

Specific Items –
(May include information related to Mental Health, Alcohol/Drug/Substance, Genetic, HIV/AIDS, Psychotherapy, & External Records.)

_____ Office Visit Notes _____ Lab Results _____Imaging Reports _____Procedure/Surgery Notes
_____Consultations _____Test Results _____Medications/Pharmacy _____Billing Reports
_____Mental Health _____HIV/AIDS _____Alcohol/Drugs/Substance Use _____Genetic Testing
_____Psychotherapy
_____ Entire medical record
(includes: Mental Health, Alcohol/Drug/Substance, Genetic, HIV/AIDS, Psychotherapy, & External Records)
_____ Other: _____
_____

TO BE OBTAINED FROM:
Facility: Antrim House
Sobriety Centers of New Hampshire
Address: 55 Main St, Antrim, NH 03440
Phone: (603) 808 – 0185 Fax: (603) 808 – 0211

TO BE RELEASED TO:
Entity: _____
Address: _____
_____
Phone: _____Fax:_____

REASON FOR RELEASE: (Check only one) _____ Criminal Justice System_____ Legal_____
Other: _____

I, THE PATIENT OR LEGAL REPRESENTATIVE OF PATIENT, UNDERSTAND:

- I understand that this consent is revocable upon the passage of the specified amount of time or there 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 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: verbal, paper, unencrypted fax/electronic.

PATIENT/REPRESENTATIVE SIGNATURE: _____Date:_____

Legal Representative Name:_____ Relationship:_____
Witness Signature:_____ Date:_____

Drug or Alcohol Abuse treatment information (covered by 42 CFR Part 2 C 2.35): The Federal rules state that a person who receives patient information relative to this consent may redisclose and use it only to carry out that persons official duties with regard to the patient's conditional release or other action in connection with which the consent is given.