



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

**Protected Health Information (PHI) Release Authorization**

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:***

FOR THE DATES OF SERVICES from \_\_\_\_\_ to \_\_\_\_\_.

**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:**

Organization or Facility: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**REASON FOR RELEASE: (Check only one)** \_\_\_\_ Transfer of Care \_\_\_\_ Ongoing Care/Specialist

\_\_\_\_ Legal    \_\_\_\_ Personal    \_\_\_\_ Billing/Insurance  
 \_\_\_\_ 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.