New Hampshire Professionals Health Program

Sally Garhart MD
Medical Director
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Assistant Medical Director

P.O. Box 6274
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603-491-5036
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Consent for the Release and Exchange of Confidential Information

I, _____, authorize
(Printed name)

release of a copy of my full medical records and two-way written and verbal communication from:

_____
(Name of Provider and Facility)

Sent to: **Sally Garhart MD**
Medical Director NH Professionals Health Program
P. O. Box 6274
603-492-5036
FAX 603-924-0161

regarding:

my psychiatric history and treatment and/or substance abuse evaluation and/or treatment records. This includes any confidential information relevant to my competence to safely and competently practice medicine including, without restriction, any information as to my physical or mental health, psychiatric history, behavior or the use of impairing substances including drugs or alcohol.

Additional documents (if applicable):

I understand that my records are protected under Federal confidentiality rules (42CFR Part 2) and cannot be further disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, or as follows:

_____
(Specify date, event or condition upon which this consent expires)

_____ _____
(Signature) **(Date)**