AUTHORIZATION AND CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION for NON-TREATING PROVIDERS

I, _____ (Name of client), date of birth ___/____/_____ authorize

_____ (Name of Entity/ Treating Provider/ Program)

to disclose to and receive from the following non-treating providers:

☐NH Professionals Health Program: Molly Rossignol, DO, Deanne Chapman MS PA-C, Peter DalPra LADC LCS, Mary Behnke RN

I understand that my medical and behavioral health and substance use disorder treatment records are protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts 160 & 164 and that my substance use disorder treatment records are further protected by the federal regulations governing the Confidentiality of Substance Use Disorder Treatment Records, 42 C.F.R. Part 2and cannot be disclosed without my written consent unless otherwise provided for by the regulations and state law.

The purpose of this consent is to authorize _____ (Name of Entity/Treating Provider/Program) to disclose and share aspects of my protected healthcare information with the above named non-treating provider and individual(s) in that non-treating provider entity for the purpose of:

☐Confirming compliance with NHPHP signed Monitoring Agreement stipulations
☐Other:_____

Specific information to be disclosed and shared include:
Check all that apply:

☐Substance use assessments and diagnoses, treatment, discharge, and/or recovery plans;
☐Mental health assessments and diagnoses treatment, discharge, and/or recovery plans;
☐Psychiatric evaluations and diagnoses, treatment, discharge, and/or recovery plans;
☐Attendance, participation, compliance, and progress in substance use disorder treatment; mental health treatment; and/or recovery support services;
☐Emergency room treatment episodes and/or Hospital admissions;
☐Medications and medication history;
☐Legal history, current pending legal charges and convictions, court orders and criminal justice requirements
☐Results of alcohol and other drug screening (urinalysis, blood, and breathalyzer);
☐Other:_____

Acknowledgement of Rights

I understand that my substance use disorder treatment records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Treatment Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations and state law. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and if so may not be protected by federal or state law, however federal law prohibits the recipient of information disclosed pursuant to this authorization from making any further disclosure of substance use disorder treatment records without the express written consent of the person to whom it pertains or as otherwise permitted by law.

This consent shall be valid until such time as _____, until date listed _____ , upon my death or until otherwise revoked by me. I understand that I may revoke this consent orally or in writing at any time except to the extent that disclosures have been made in reliance on it.

Upon request, I can inspect or obtain a copy of the information I am authorizing to be released and I can receive a list of all disclosures that have been made, to whom and when they were made.

I understand that I may be denied services if I refuse to consent to a disclosure for the purposes of my treatment, payment or healthcare operations if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I acknowledge that I have been given a copy of this consent form.

_____ _____
Signature of Patient or legal representative or guardian Date

_____
Authority/Relationship of representative to patient