AUTHORIZATION FORM FOR RELEASE OF DRUG AND/OR ALCOHOL TREATMENT INFORMATION

Great Bay Mental Health Associates, Inc.
311 Route 108 Suite 204
Somersworth NH 03878

Patient Name:______________________________________ DOB:____________

I authorize **Great Bay Mental Health Associates, Inc** (**"GBMHA"**) to the use or disclosure of the above-named individual's personal health information as described below.

Name and Address of Individual or Entity this Information may be disclosed to:____

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The type and amount of information relating to drug and/or alcohol treatment to be used or disclosed is as follows:

Diagnostic, testing, and treatment information
Referral/intake information
Progress or similar notes
Social, family, educational, and vocational histories and assessments
Evaluation and reports of consultants
Treatment or similar plans
Other

Purpose of Disclosure: ____

Methods of Disclosure Authorized: Faxed, written, phone conversation, in-person and/or secure e-mail

- I understand that I have the right to revoke this authorization in writing, at any time by presenting written notification to GBMHA. Revocation will be effective as of the date received.
- I understand that a revocation will not be effective to the extent that GBMHA has taken action in reliance on the authorization prior to the revocation date, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my clinician generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.
- I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by federal privacy regulations.
- I understand that I have the right to: 1.Inspect or copy the protected heath information to be used or disclosed as permitted under Federal law; 2. Refuse to sign this authorization.
- Unless otherwise revoked, I understand this authorization expires on the earlier of one year of date signed or ______________________________. (If left blank, the authorization will expire one year from the date signed).

Signature of Patient and/or Legal Representative: ______________________________ Date ___________

To the Receiving Provider : This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical information or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.