HARBOR HOMES, INC.
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
TEL # 603-821-7788 FAX # 603-821-5620

I, _____(Patient/Client), DOB _____,
whose address is _____,
authorize Harbor Homes, Inc. to disclose to and/or obtain my protected health information described below from:
_____
for the following purpose: _____("at patient request" is sufficient).
Dates of care: _____
Description of Information to be Disclosed (Patient/client must initial each item to be disclosed):

___ Copy of complete medical record ___ Medical reports
___ Discharge Summary ___ Laboratory reports
___ Initial Evaluation ___ Psychiatric Evaluations
___ Medications ___ Psychotherapy Notes
___ Other (specify) _____

If my initials appear here, ___ I specifically authorize release of drug/alcohol abuse and or psychiatric records. Federal law 42CFR Part 2 prohibits those receiving information on drugs or alcohol treatment from re-disclosing it unless further disclosure is expressly permitted by written consent of the person to whom it pertains, or is otherwise permitted by 42CFR Part 2.

If my initials appear here ___, I specifically authorize release of my HIV test results for the purpose set forth above. My signature below indicates I have read this form, have asked all the questions I have about the reason for the release of my identity, the results of my HIV test and I agree to the release of information to the above named party.

If my initials appear here ___, I specifically authorize release of my records that contain information about my diagnosis or treatment for AIDS or ARC, or contain some other reference to my identity as an AIDS or ARC patient for the purpose set above.
I understand that I have the right to revoke this authorization, in writing, at any time by sending notification to Harbor Homes, Inc. at 45 High Street, Nashua, NH 03060. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

I further understand that Harbor Homes, Inc. will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: I understand that I might be denied services if I refuse to consent to a disclosure for the purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to sign this form for a disclosure for other purposes.

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including but not limited to, verbally, in paper format or electronically.

I understand that I may inspect or copy the protected health insurance described in this authorization.
I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I understand that by authorizing this release of my medical information, I also release the care provider from all legal responsibility or liability that may arise from the release of this medical information.

EXPIRATION: This authorization will expire on (date/event) _____. If no date or event is specified, the authorization shall expire six months from the date it was signed. A photocopy of this authorization shall be considered as effective and valid as the original. A copy of this authorization shall be provided to the consumer or representative when signed.

_____

Signature of Patient/Client Date

_____

Signature of Parent/Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare
surrogate, etc)

___ Check here if patient/client refuses to sign authorization.

_____

Signature of Staff Witness Date