New Approaches

Protected Health Information (PHI) Release Authorization - Criminal Justice

Applies to: information related to criminal justice system duty to monitor patient progress (prosecuting attorney, court, probation, parole.

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 SERVICE 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: New Approaches

Address: 463 Washington Street Keene NH 03431

Phone: (603)305-0965 Fax: _____

TO BE RELEASED TO:

Entity: _____

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.