813 Beech Street
Manchester, NH 03104
603-669-7361

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Resident Name: _____
Date of Birth: _____

I give my consent to (doctor's name): _____ to release the last six months of information from my medical record to: (Name of person/facility to get records):

Admissions
Evergreen Place
813 Beech St.
Manchester NH 03104
Fax: 603-606-5656

I understand that my medical record may contain information relating to drug and/or alcohol abuse, psychiatric history, sexually transmitted infections, social services, HIV (AIDS) testing and treatment records, genetic testing and/or sensitive information. I agree to release all records except as noted below.

Please "X" out those records you do **NOT** want released:

- ☐ Drug/alcohol Abuse Notes
- ☐ Sexually Transmitted Disease Notes
- ☐ HIV (AIDS) Testing and Notes
- ☐ Psychiatric Notes
- ☐ Social Services
- ☐ Genetic Testing

I understand I may revoke this authorization at any time. This authorization will expire on _____ or in one year if a date is not entered.

Patient/Authorized Representative Signature Date

Witness Signature Date

EVERGREEN PLACE WILL NOT DISCLOSE INORMATION COLLECTED TO ANY SOURCE OTHER THAN WHAT HAS BEEN AUTHORIZED UNDER THE HIPAA PRIVACY ACT. THE INFORMATION COLLECTED WILL BE USED TO DETERMINE CARE NEEDS.