Harbor Care
HOUSING • HEALTHCARE • VETERAN SERVICES

AUTHORIZATION AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION, MENTAL HEALTH TREATMENT RECORDS & SUBSTANCE USE TREATMENT RECORDS OUTSIDE OF HARBOR HOMES, Inc. d/b/a HARBOR CARE

I, _____(Print name of client/patient), date of birth _____/____/_____ authorize Harbor Homes, Inc. d/b/a Harbor Care (inclusive of Keystone Hall and Harbor Care Health and Wellness Center) to disclose, receive, and share my medical, mental health, and/or substance use disorder protected health information (PHI) with those entities and individuals listed below.

I understand my treating providers at Harbor Care will be providing and helping to coordinate aspects of my care and treatment and will therefore need to share certain private health information about my referral, diagnosis and/or treatment for physical health, mental health and/or substance use disorder with my treatment team, with other treating providers, with other individuals or entities involved in my treatment and/or recovery, with entities responsible for payment, and with others listed below as authorized by me or by law.

I authorize Harbor Care to access, use, disclose and communicate both verbally and in writing, private health, substance use disorder and mental health information, including: **[initial all that apply]**

____ My health care/treatment records
____ Test, laboratory and radiology results
____ Medications and medication history
Substance use disorder history and report of current use, treatment history, treatment records, assessments, diagnoses, treatment plans, attendance, compliance and progress in treatment, progress notes, discharge summaries, and recovery plans/supports.
____ Confirmation of Participation in Treatment Only
____ I also authorize my treating providers at Harbor Care to release and share information regarding my treatment for HIV infection, AIDS and/or STD's.
____ Other:(specify)_____

I authorize Harbor Care to access, use, disclose and communicate verbally, electronically or in writing as noted above to my past, present, and future treating providers at the following entities for the purpose of my ongoing treatment and recovery and helping me manage my care: **[initial all that apply]**

____(Name of Agency /Tel #) _____
____(Name of Agency /Tel #) _____
____(Name of Agency /Tel #) _____
____(Name of Agency /Tel #) _____
____(Name of Agency /Tel #) _____

____Other: (specify)_____

For the purpose of: [initial all that apply]

____Monitoring and supporting my ongoing recovery
____ Assessing/evaluating my readiness/ability to participate in housing/employment/vocational training
____Confirming compliance with court ordered treatment, probation or parole
____For the purpose of the care and treatment of my children
____Coordination of community-based care
___ *Other:*_____

Acknowledgement of Rights

I understand that my substance use disorder treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient 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. I understand that if my substance use treatment records are disclosed pursuant to this consent, the recipient will be provided a notice of prohibition on re-disclosure. I understand that if my general PHI (i.e. not SUD related) is released pursuant to this consent, the PHI will be subject to re-disclosure by the recipient.

Revocation

I understand that I may revoke this consent, orally or in writing by contacting the Privacy Officer at Harbor Care at 603-816-6383 at any time except to the extent that action has been taken in reliance on it. I understand that Harbor Care is unable to take back any disclosures it has already made with my consent. I understand that Harbor Care may not condition treatment on my signing this authorization except if I am receiving substance use treatment services and I refuse to authorize disclosure of my health information for payment purposes.

If not already revoked, this consent will expire on_____. [Example: One year/specified date/upon my death]

Upon request, I can inspect or obtain a copy of the information I am authorizing to be released. I understand that if I have any questions about disclosure of my substance use treatment records or information, I can contact Harbor Care's Compliance Officer at 603-816-6383.

Signature of Patient or Legal Representative

_____ _____
Signature of patient, legal representative or guardian Date

_____
Authority/Relationship of representative to patient (Attach copy of documentation of authority)