Lakes Region Mental Health Center

PCP Release of Information

Name | Date of Birth | Case Number

Formerly Known As (if applicable)

Medical Records Should:
☐ Request Outside Records ☐ Send Out Records ☐ File

I authorize Lakes Region Mental Health to:
☐ Receive from
☐ Disclose to
☐ Having ongoing verbal comunication

Purpose ☐ Continuity of Care ☐ Other (see comment)

PCP Name and Address

Name

Address

City | State | Zip

Telephone # | Fax #

Please Send Records to

☐ 40 Beacon Street East, Laconia, NH 03246
Phone: 603-524-1100 Fax: 603-527-8104

☐ 81 Highland Street, Plymouth, NH 03264
Phone: 603-536-1118 Fax: 603-536-1028

Records Dates Records to be Obtained/Released ☐ All ☐ OR From: To:

Select all that apply

- ☐ Intake/Admission Summary(s)
- ☐ Discharge Summary(s)
- ☐ Medical/Psychiatric Evaluations
- ☐ Medical Progress Notes
- ☐ Treatment Summary(s)
- ☐ Medication List/History
- ☐ Test Results
- ☐ Education Plans
- ☐ One Health - PCP Notes
- ☐ Laboratory Results
- ☐ Treatment Plan
- ☐ History and Physical
- ☐ Progress Notes/ES Evaluation/ES Stabilization
- ☐ Letters
- ☐ Other (see comment)

I authorize my treating providers at LAKES REGION MENTAL HEALTH CENTER to access, use, disclose and communicate orally, in writing and electronically my private health care information including information pertaining to substance use disorder treatment, physical health, and mental health treatment information for the purpose of treatment, payment and healthcare operation and as otherwise authorized by law. I also authorize my treating providers at LAKES REGION MENTAL HEALTH CENTER to release and share information regarding my treatment for HIV infection, AIDS and STD'S.

Acknowledgement of Rights.

I understand that my substance use disorder treatment records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Treatment 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 and state law. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and if so may not be protected by federal or state law; however federal law prohibits the recipient of information disclosed pursuant to this authorization from making any further disclosure of substance use disorder treatment records without the express written consent of the person to whom it pertains or as otherwise permitted by law.

This consent shall be valid for one(1) year, upon my death, or until otherwise revoked by me. I understand that I may revoke this consent in writing at any time except to the extent that disclosures have been made in reliance on it.

Patient/Parent/Guardian Signature(s)

Patient

Date Signed

Parent/Guardian

Date Signed

Authority/Relationship of representative to patient (attach a copy of documentation of authority to sign for the patient)

Parent/Guardian

Date Signed

Authority/Relationship of representative to patient (attach a copy of documentation of authority to sign for the patient)

☐ Patient Declined

I DO NOT give permission to Lakes Region Mental Health and my Primary Care Physician to share information about my diagnosis and/or treatment related to substance, mental, or medical history, including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care

Patient

Date Signed

Witness/Staff Signatures

Date Signed