Summerhill
Assisted Living & Memory Care Community

AUTHORIZATION TO DISCLOSE/USE PROTECTED HEALTH INFORMATION

I authorize Summerhill Assisted Living (Summerhill) to disclose protected health information:

_____ _____
Print **Name** of person whose protected health information is to be released Print **Date of Birth**

To: Summerhill Assisted Living

183 Old Dublin Road, Peterborough, NH 03458

I authorize Summerhill to obtain my protected health information from (name of doctor):

_____
Print **Name** of provider of protected health information

_____
Print **Address** of provider of protected health information

Health information includes information collected from me or created by Summerhill or another Provider, which may relate to my past, present or future physical or mental health condition, the provision of my health care, or payment for my health services.

Any Provider that operates a federally assisted alcohol or drug abuse program is prohibited from disclosing information about treatment for alcohol or drug abuse without my specific written authorization unless a discloser is otherwise authorized by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

Please initial as appropriate:

_____ I specifically authorize disclosure of information concerning my alcohol or drug abuse treatment.
_____ I specifically authorize disclosure of information concerning HIV/AIDS status.
__X__ I specifically authorize use of information for the purpose stated below.

The purpose(s) of this Authorization is (are):

_X_ Specifically, the following purpose(s): To Obtain Medical History
_____
_____

___ This request has been initiated by the Client and the Client does not elect to disclose its purpose.

Note: This box may NOT be checked if the information to be used or disclosed pertains to alcohol or drug abuse diagnosis, prognosis, or treatment.

Over Please

I Authorize disclosure or use of the following protected health information: *(check all that apply)*

_X_ Oral exchanges of relevant health information between Summerhill and (name of doctor)_____

_X_ All health information about me, including my clinical records, created or received by the Provider;

___ All health information about me created or received by the Provider *excluding* the following:
_____
_____.

___ Only the following information:

___	Social History	___	Psychiatric History
___	Substance Use/Abuse History	___	Intake Summary/Clinical Database
___	Psychiatric/Psychological Evaluation	___	Discharge/Termination Summary
___	School Records/Testing	___	Most recent Treatment Plan
___	Medical History/ Lab Reports	___	Most recent Medication List

Other: _____
_____

ACKNOWLEDGMENT

1. I understand that SUMMERHILL CANNOT GUARANTEE THAT THE RECIPIENT WILL NOT REDISCLOSE my protected health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information.

2. I understand that MY TREATMENT AT SUMMERHILL MAY NOT BE CONDITIONED ON MY AGREEMENT TO AUTHORIZE DISCLOSURE OR USE of my health information.

3. I understand that I MAY REVOKE this Authorization in writing at any time, except that the revocation will not have any effect on action taken by the Provider based on this Authorization before written notice of revocation is received by the Provider. Written revocation may be addressed to our Executive Director.

4. I have had the opportunity to discuss this document and I UNDERSTAND AND AGREE to the terms of this Authorization.

Date of Signature: _____

_____
Signature of Client/Legal Representative

_____
Relationship of Legal Representative

This Authorization shall automatically expire **ONE (1) YEAR** from date of signature, or on _____ (specify date or event).

A photocopy of this Authorization shall be considered effective and valid.