



**HIPAA & 42 CFR Part 2 Authorization for Use and Disclosure
of Protected Health Information (PHI)**

Patient Information

- Patient Name: _____
- Date of Birth: _____
- Phone Number: _____
- Medical Record Number (if applicable): _____

Authorization

I authorize

Person's Name or Organization:	Telephone Number:
Address: (including zip code)	Fax Number:

to use and disclose my protected health information (PHI), including records related to substance use disorder diagnosis, treatment, or referral for treatment, in accordance with HIPAA (45 CFR Parts 160 & 164) and 42 CFR Part 2, as amended.

Information to Be Used or Disclosed

This authorization applies only to the information you select below.

Please check each box that applies to the information you want released.

If you do not want a category released, leave the box blank.

All health records (includes all categories listed below)

OR select specific records:

- Mental health records
- Substance use disorder treatment records (Part 2-protected)
- Medication records
- Treatment plans and clinical notes
- Billing and payment records
- Other: _____



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Purpose of Disclosure

The purpose of this use or disclosure is (check all that apply):

- Treatment
- Payment
- Health care operations
- Care coordination
- Eligibility determination
- Quality assessment or improvement
- Marketing
- Other: _____

Persons or Entities Authorized to Receive Information

This information may be disclosed to:

Saco River Medical Group

7 Greenwood Ave

Conway NH 03818

(P) 603-447-3500

(F) 603-447-5568

This authorization allows disclosure to a class of recipients as permitted by 42 CFR Part 2.

Redisclosure

I understand that my information may be redisclosed by the recipient as permitted by HIPAA and 42 CFR Part 2. Redisclosure for civil, criminal, administrative, or legislative proceedings is not permitted unless expressly authorized by law or court order.



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Patient Rights

- I understand that I may revoke this authorization at any time by submitting a written request, except to the extent action has already been taken.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this authorization (unless permitted by law).
- I understand that I have the right to receive a copy of this authorization.

Expiration

This authorization will expire on:

- A specific date: _____
- Upon the occurrence of the following event: _____
- One (1) year from the date of signature

Part 2 Notice (Required Statement)

This information has been disclosed to you from records protected by 42 CFR Part 2. Federal law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the individual to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Signature

I acknowledge that I have read and understand this authorization.

- Patient / Legal Representative Name: _____
- Signature: _____
- Date: _____

If signed by a legal representative (if applicable), relationship to patient:
