



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

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:

- |   |  |
|---|--|
| <input type="checkbox"/> Drug/alcohol Abuse Notes           | <input type="checkbox"/> Psychiatric Notes |
| <input type="checkbox"/> Sexually Transmitted Disease Notes | <input type="checkbox"/> Social Services   |
| <input type="checkbox"/> HIV (AIDS) Testing and Notes       | <input type="checkbox"/> 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.

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Patient/Authorized Representative Signature

Date

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Witness Signature

Date

EVERGREEN PLACE WILL NOT DISCLOSE INFORMATION 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.