Gateways Community Services
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

General Information Regarding This Authorization

- This Authorization permits Gateways Community Services to use or disclose your Protected Health Information for purposes other than your treatment, payment to the Gateways Community Services or the health care operations of Gateways Community Services. You have the right to revoke this Authorization by providing Gateways Community Services with written notice of revocation. The revocation will be effective upon receipt by Gateways Community Services except with respect to uses or disclosures made prior to receipt and in reliance upon this Authorization.

- Gateways Community Services cannot require you to sign this Authorization as a condition to the provision of services.

- Please note that once the requested information is disclosed pursuant to this Authorization, Gateways Community Services will no longer have control over the information and there is a potential that it may be re-disclosed by the recipient and will no longer be protected by the privacy rules under the Health Insurance Portability and Accountability Act.

AUTHORIZATION

I hereby authorize Gateways Community Services or any of its staff to use or to disclose, by any acceptable means, including fax or email, my Protected Health Information described as follows

Medical reports showing diagnosis	Current physical exam report
Recent psychological, if available	Functional assessment and IQ tests
Neurological and other evaluations	Any other pertinent information

or to request the above information from the following persons or class of persons (include name, address and telephone number):

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The purpose of the requested use or disclosure is:

____

If applicable, please initial the appropriate blank in the following two statements:

1. *Alcohol/Drug Treatment Records*. I do ___/ I do not ___ authorize the use or disclosure of drug or alcohol abuse treatment records. I understand that these records are protected under federal regulations (42 CFR Part 2). I understand that I have the right to refuse to release this information. If alcohol or drug abuse treatment records are disclosed, the following notice shall be included with the records:

> "This information has been disclosed to you from our records and is protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

2. *HIV Status*. I do ___/ I do not ___ authorize the release of HIV test results for the purpose set forth above.

This Authorization shall expire on __________, 20__, which is no more than one year after its effective date, unless it is revoked prior to the expiration date.

Witness Signature	Signature of Consumer or Legal Representative
Print Name of Witness	Print Name of Consumer
	Consumer DOB:
Date signed	Print Name of Legal Representative

Please return requested information to the address below.

Gateways Community Services
144 Canal ST Nashua NH 03064

Approved Sep. 26, 2002