**ALL PATIENTS**

Federal and state laws ensure that communication between you and your medical providers are confidential. We cannot and will not disclose your medical records to anyone else unless you authorize us in writing to do so or under certain legal exemptions to this law. If you would like further information about the law of Physician/Patient privilege or its limitations, please speak to someone on your treatment team.

Patient Printed Name: ________________________________ Date:_____________

Patient/Parent Signature: _________________________________ Date: ______________

**ALL PATIENTS**

I understand and authorize Goodwin Community Health to disclose and release personal health information about me or my child, whoever is the patient, and this specifically includes alcohol or drug information , if applicable, which is protected by *42CFR part 2* to my or my child's referring/mutual provider of care.

For more information about *42CFR part 2*, refer to page 22 of your patient handbook. If you do not have a copy of the patient handbook please ask a staff person at the front office for a copy.

Patient/Parent Signature: _________________________________ Date: ______________

Minor’s Signature (if 12 years and older) _____________________________ Date: _________

**MINORS**

You need to know New Hampshire law requires we report any physical or sexual abuse, past or present, because of your age to DCYF.

Because the results of being abused can affect us for the rest of our lives, it is very important to get help as early as possible. If you don’t wish to tell us, please consider talking with another trusted adult.

Patient/Parent Signature: _________________________________ Date: ______________

**FOR OFFICE USE ONLY:**

Staff Signature: __________________________________________ Date: _______________

Confidential Client:

- ❑ Yes If Yes, Emergency Information______________________________________
- ❑ No