Weeks Medical Center

8 Clover Lane
Whitefield, NH 03598
FAX 603-788-5072
PH 603-837-9005

47 Church Street
Groveton, NH 03582
FAX 603-788-5059
PH 603-636-1101

43 Main Street
No. Stratford NH 03590
Fax: 603-922-5502
PH: 603-922-5039

170 Middle Street
Lancaster, NH 03584
FAX 603-788-5092
PH 603-788-2521

Authorization For Disclosure of Protected Health Information to Patient Portal

All sections of this form must be filled out completely or it will not be accepted.

I hereby authorize Weeks Medical Center (WMC) to use/disclose my individually identifiable health information to Patient Portal (which may include information concerning treatment for drug/alcohol abuse, mental health, HIV status, or genetic testing records, if applicable).

My Full Name_____
PRINTED: FIRST NAME MIDDLE NAME LAST NAME

Date of Birth_____

Mailing Address_____
PRINTED: STREET OR POST OFFICE BOX TOWN/CITY STATE ZIP

eMail address where patient portal messages will be sent to : _____
PLEASE PRINT

- I understand that my health care and the payment of my health care will not be affected if I do not sign this form.
- I understand that I MAY REFUSE TO SIGN THIS AUTHORIZATION. I also understand that Weeks Medical Center shall not refuse to treat me if I refuse to sign this authorization.
- Weeks Medical Center is not responsible for a breach of this information if the patient using the portal is using a computer workstation or device that could be compromised.
- I understand that this authorization MAY BE REVOKED in writing and delivered to Weeks Medical Center, Medical Records Dept, 173 Middle St, Lancaster, NH 03584 at any time requesting that my account be inactivated.

_____ _____ _____
Date Signature of individual or representative Relationship if representative

For office use only
☐ email address entered in Paragon Registration by _____ on _____
Initials date
☐patient activated by _____ on _____
Initials date
- ✓ Verified email address
- ✓ Mailed user name and password to patient
- ✓ Form scanned into eCW