

**Authorization for Disclosure of Protected Health Information**

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 as described below (which may include information concerning treatment for drug/alcohol abuse, mental health, HIV status, or genetic testing records, if applicable). 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 if the recipient authorized to receive the information is not a covered entity, such as an insurance company or health care provider, the disclosed information may no longer be protected by federal and state privacy regulations.

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone number \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_

Address \_\_\_\_\_

Phone number \_\_\_\_\_ Fax number \_\_\_\_\_

To Disclose my protected health information to WEEKS MEDICAL CENTER

Address 173 MIDDLE STREET, LANCASTER N.H. 03584

as described below,

Check all that apply:

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> Discharge Summary <b>PAST 2 YEARS</b>              | <input checked="" type="checkbox"/> Laboratory Data- <b>PAST 2 YEARS</b>         |
| <input checked="" type="checkbox"/> History & Physical Exam- <b>MOST RECENT</b>        | <input checked="" type="checkbox"/> E.R. Records- <b>PAST 2 YEARS</b>            |
| <input checked="" type="checkbox"/> Operative Notes- <b>ALL DATES</b>                  | <input checked="" type="checkbox"/> E.K.G.- <b>PAST 2 YEARS</b>                  |
| <input checked="" type="checkbox"/> Consultations- <b>PAST 2 YEARS</b>                 | <input checked="" type="checkbox"/> Pathology – <b>ALL DATES</b>                 |
| <input checked="" type="checkbox"/> Mental Health progress notes- <b>PAST 2 YEAR</b>   | <input checked="" type="checkbox"/> Inpatient Psych Notes- <b>PAST 2 YEARS</b>   |
| <input checked="" type="checkbox"/> Progress Notes/Office Notes- <b>PAST 2 YEARS</b>   | <input checked="" type="checkbox"/> Immunizations                                |
| <input checked="" type="checkbox"/> X-Ray, Scans, Ultrasound, Mammos- <b>ALL DATES</b> | <input checked="" type="checkbox"/> HIV/AIDS/STD testing/treatment- <b>1YEAR</b> |
| <input checked="" type="checkbox"/> Drug/alcohol testing/treatment- <b>PAST 1 YEAR</b> | <input type="checkbox"/>   |

Dates of care included PER ABOVE to PER ABOVE

- Continued Medical Treatment  At the request of the individual
- Transfer of care (Effective Date) \_\_\_\_\_
- Other (explanation required) \_\_\_\_\_

- 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.
- 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, although the revocation will not be effective to previously released protected health information pursuant to a valid authorization.
- I understand that if I authorize disclosure of protected health information, the recipient may further disclose this information, and it may no longer be protected by federal or state rules.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of individual or representative/ Authority or relationship of representative  
(Attach copy of documentation of authority)

EXPIRATION DATE: This authorization will expire on (no later than one year from today) \_\_\_\_\_  
(If no date is stated, this authorization expires one year from the date it was signed)

May 2018  
REVISED 4-2019

COPY PROVIDED: The subject individual will be provided a copy of this authorization.

\*\*\*\*This information has been disclosed to you from records 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 the written consent of the person whom it pertains or as otherwise permitted by (42 CFR Part 2).

