Office Practice
173 Middle Street
Lancaster, NH 03584
Fax 603-788-5092
Phone 603-788-2521

NCH north country healthcare | Weeks Medical Center

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:

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

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)

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

May 2018
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****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).

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