NCH north country healthcare | Weeks Medical Center

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

Authorization for Release Of Information

Please complete all sections. Missing information may cause delays or the inability to retrieve your records Release may take up to 30 days to process.

Please Print Patient Information *must be fully completed*

Name:_____ Previous name:_____ Date of Birth_____

Address:_____ Phone:_____

City:_____ State:_____ Zip Code: _____

***Who** has the information you want released.*

Please list the specific hospital, physician office and/or home health agency

Provider:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip Code:_____ Fax: _____

Who *do you want to receive your information*

I hereby authorize the above-named hospital/physician office to release medical records as described below.

Name:_____ Attention to: _____

Address:_____ Phone:_____

City:_____ State:_____ Zip Code:_____ Fax: _____

Information to be released:

What *do you want shared? Check appropriate boxes*

Date(s) of service From:_____ To:_____

We do not accept "ALL" for dates of service, if left blank the last 2 years will be sent

Description of information to be released: (check all that apply)

____Discharge Summary	____Laboratory Report	__ Physician Orders	____Cardiology
____Emergency Dept	____Radiology Report	____Rehab PT/OT/ST	____X-ray films/CD
____Urgent Care	____Pathology	____Chart Summary	____Billing records
____History & Physical	____Operative Reports	____Progress Notes/Office notes	
____Abstract (summary of visits and all tests)		____Consultations	____Immunizations
____Other_____			

Sensitive Information (**INITIAL** to be released)

____Drug and Alcohol testing and/or treatment Records	____HIV/AIDS/STD testing and/or treatment Records
____Psychiatric Evaluation	____Mental Health Progress Notes
____Treatment Plan	____Medication History
____Intake Assessment	____Evaluations

Purpose of release *(Why is it needed)*

❑Continuing Care ❑ Transfer of Care ❑ Personal Use/Review ❑ Insurance ❑ Workers Compensation

❑ Attorney ❑Temporary Transfer of care (school/winter away) ❑ Other(specify):_____

Fees may be charged in accordance with State and Federal Statutes

-RELEASE

I understand that:

- I can refuse to disclose some or all of the information in my record, but refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences
- I can revoke all or part of this authorization at any time during this time period by providing written notice to the Health Information Management Department, **except** where this authorization already has been acted on for release of my protected health information. Such revocation may be the basis for denial of health benefits of other insurance coverage or benefits
- I understand that if protected health information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be re-disclosed by the individual or entity that receives this information
- I understand I am entitled to a copy of this authorization, upon request
- If any of the information disclosed pursuant to this request is from records protected by Federal confidentiality rules at 42 CFR Part 2, those rules prohibit the recipient from making any further disclosure of this information unless I expressly permit it through my written consent or redisclosure is performed as otherwise permitted in 42 CFR Part 2.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____
I understand that if I fail to specify an expiration date, event or condition, this authorization will expire 6 months from date signed. I also understand it is my responsibility if I document a long expiration date to cancel in writing to Weeks Medical Center I wish to change.

Signature of Patient or Authorized Representative _____

Printed Name _____

Relationship of Authorized Representative (e.g. Parent, Guardian, Power of Attorney) _____

Date_____ **Time** _____

FOR OFFICE USE ONLY

Medical Record # _____
Visit ID _____
Telephone request ( ) Date:___
Charge: Yes Or No
By Whom: _____
Info to be ( ) Faxed ( ) Mailed ( ) Picked up ( )
Handed Date/Time to be mailed, etc: _____
Date Completed: