Office Practice
173 Middle Street
Lancaster, NH 03584

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.

Patient Information:

Full Name:_____ Date of Birth: _____

Address:_____ Phone number: _____

I authorize the following facility/provider:

_____

Address: _____

_____

Phone number:_____

Fax number: _____

To Disclose my protected health information as described below to:

Weeks Medical Center

Health Information Management Department

Address: 173 Middle Street Lancaster, NH 03584

Phone number: 603-788-5636

Fax number: 603-788-5092

The Following Information is being requested:

Discharge Summary **PAST 2 YEARS**
Physical Exam-**MOST RECENT**
Operative Notes-**ALL DATES**
Progress Notes/Office Notes- **PAST 2 YEARS**
X-Ray, Scans, Ultrasound -**PAST 2 YEARS**
Mammos- **ALL DATES**
Laboratory Data- **PAST 2 YEARS**
E.R. Records- **PAST 2 YEARS**
E.K.G.- **PAST 2 YEARS**
Immunizations – **ALL DATES**
Pathology – **ALL DATES**
Cytology (Pap Smears)**- ALL DATES**

For the purpose of transferring care

To request the release of the following sensitive information, you must initial below

_____Mental Health progress notes- **PAST 2 YEARS**
_____Drug/alcohol testing/treatment-**PAST 1 YEAR**
_____HIV/AIDS/STD testing/treatment- **PAST 1 YEAR**
_____Inpatient Psych Notes- **PAST 2 YEARS**

- 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 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 that I have the right to refuse to sign this form and Weeks Medical Center will not condition treatment on providing or refusing to provide this authorization. The only circumstance where refusal to sign means I will not receive services is if the services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

Signature of Patient or Authorized Representative: _____

Printed Name: _____

Date: _____

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
REVISED 01-2023

-RECORDSREQUEST