north country healthcare

NORTH COUNTRY HEALTHCARE
AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

You may tear off this page and retain it for your records.

By signing this authorization, you are permitting the use and/or disclosure of your health information for the limited purpose(s), and in the limited manner, described in this form. Except as authorized by this form, we are required by federal law to maintain the privacy of your health information as described in our Notice of Privacy Practices.

Refusals of Service
If the only reason you have asked us to provide a health care service is so that we can create information to be disclosed to a third party, we may refuse to provide the service if you refuse to sign this authorization. For example, if you have requested a drug test solely for the purpose of having the results disclosed to your employer, we may refuse to perform the drug test if you refuse to sign this authorization permitting us to disclose the results to your employer.

Otherwise, your ability to receive treatment, payment, enrollment in a plan, or eligibility for a benefit does not depend on your signing this form. **You may refuse to sign this form.**

(Note to Workforce Members Presenting this Form: If the treatment of the patient, payment for the patient's care, or enrollment of the patient in a health plan is conditioned on the patient signing this form, no use or disclosure other than that upon which treatment, payment, or enrollment has been conditioned can be authorized on this form. A separate authorization would be needed for any other use or disclosure.)

Consequences of Signing this Form
Signing this authorization may cause the health information used or disclosed pursuant to this authorization to no longer receive the protections of federal privacy laws. Any person or organization to whom your health information is disclosed pursuant to this authorization might be able to legally re-disclose that information to others.

Revocation
You may revoke this authorization at any time, in writing, except to the extent that we have already relied upon it in making a use or disclosure. Your written revocation will become effective when we have knowledge of it. If you are providing this authorization to obtain insurance coverage, you may not have the right to revoke the authorization to the extent that it pertains to the insurer's right under law to contest a claim under your insurance policy. If you wish to revoke this authorization, please send your written request to: Privacy Officer, North Country Healthcare, 59 Page Hill Road, Berlin, NH, 03570.

Expiration
Once this authorization has expired, we will no longer use or disclose your health information for the purpose listed in this authorization unless you sign a new authorization form.

NCH
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Androscoggin Valley Hospital
North Country Home Health & Hospice Agency
Upper Connecticut Valley Hospital
Weeks Medical Center

Authorization for Release of Information

AVH	Fax: 603-326-5832	Phone: 603-326-5833
UCVH/ISHC	Fax: 603-237-4145	Phone: 603-388-4300
Weeks	Fax: 603-788-5054	Phone: 603-788-5636
NCHHHA	Fax: 603-444-0980	Phone: 603-444-5317

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

Section 1: Please Print Patient Information *must be fully completed*

Name:_____ Previous Name:_____ Date of Birth:_____

Address:_____ Phone: _____

City:_____ State:_____ Zip Code: _____

Section 2: Who *has the information you want released.*

- ☐ Androscoggin Valley Hospital, 59 Page Hill Rd, Berlin, NH 03570
- ☐ Indian Stream Health Center, 181 Corliss Lane, Colebrook, NH 03576 (via UCVH as record holder)
- ☐ Upper Connecticut Valley Hospital, 181 Corliss Lane, Colebrook, NH 03576
- ☐ Weeks Medical Center, 173 Middle St, Lancaster NH 03584
- ☐ North Country Home Health & Hospice Agency, 536 Cottage St, Littleton, NH 03561
- ☐ Other facility/Provider:_____

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

Address:_____ Phone: _____

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

Section 3: Who *do you want do receive your information*

Name: _____ Attention to: _____

Address:_____ Phone: _____

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

Section 4: Information to be released

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

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

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

What do you want shared? Check appropriate boxes

- ☐ Discharge Summary
- ☐ Emergency Dept
- ☐ History & Physical
- ☐ Operative/Procedure Reports
- ☐ Office Notes/Progress Notes
- ☐ Other _____
- ☐ Laboratory Report
- ☐ Radiology Report
- ☐ Pathology
- ☐ Medication Lists
- ☐ Physician Orders
- ☐ Rehab PT/OT/ST
- ☐ Consultations
- ☐ HH/Care Plans
- ☐ HH/Treatment notes
- ☐ Cardiology/EKG
- ☐ Imaging CD
- ☐ Billing Records
- ☐ Immunizations

Sensitive Information 42 CFR Part 2 (**INITIAL all that apply)**

- _____ Drug and Alcohol Testing
- _____ Drug and Alcohol Treatment Records
- _____ Psychiatric Evaluations
- _____ Treatment Plan
- _____ Intake Assessment/Screening
- _____ HIV/AIDS/STD Testing
- _____ HIV/AIDS/STD Treatment Records
- _____ Mental Health Progress Notes
- _____ Medication List

Section 5: Purpose of Release (why is it needed?)

- ☐ Continuing Care
- ☐ Transfer of Care
- ☐ Personal Use/Review
- ☐ Workers Compensation
- ☐ Attorney
- ☐ Temporary Transfer of care (school/winter away)
- ☐ Insurance
- ☐ Other (specify): _____

Fees may be charged in accordance with State and Federal Statutes

AFFIX PATIENT LABEL

Section 6:

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 my be re-disclosed by the individual or entity that receives this information.
- I understand that I am entitled to a copy of this authorization, upon my 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 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.

Section 7:

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 1 year from date signed unless revoked in writing.

Section 8:

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

MR# _____ **Account #(s)** _____

ROI # _____ _____

Received on: _____ **Received by (initials):** _____ _____

Received at:

☐ **AVH** ☐ **UCVH** ☐ **WMC** ☐ **NCHHHA**

Completed on: _____ **Completed by (initials):** _____

Date mailed/faxed/picked up: _____

Records to be released via:

☐ **Mail (USPS)** ☐ **Fax** ☐ **Handed/Picked up**

Number of pages: _____

Charge: $ _____

Tracking# (when used): _____

AFFIX PATIENT LABEL