NCH north country healthcare

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

Adult New Patient Record Request

Authorization for Disclosure of Protected Health Information

All sections of this form **MUST** be filled out completely or it will not be accepted and scheduling will be delayed. A separate authorization needs to be completed for each facility.

Patient Information:

Full Name: _____

Date of Birth: _____

Address: _____

_____

Phone Number: _____

I authorize the following facility/provider:

_____

_____

Address:_____

_____

Phone Number: _____

Fax Number: _____

To disclose my Medical Records to:

Weeks Medical Center Attn: New Patients
Health Information Management Department
Address: 173 Middle Street Lancaster, NH 03584
Phone Number: 603-788-5636
Fax Number: 603-788-5040
** Please Mail if over 50 Pages

The following information is being requested for the purpose of transferring care:

Immunizations- **ALL DATES**
Operative Notes- **ALL DATES**
Cytology (Pap Smears)- **ALL DATES**
Mammograms- **ALL DATES**
Bone Density/DEXA Scan- **ALL DATES**
AAA Screenings- **MOST RECENT ONLY**
PSA Lab- **MOST RECENT ONLY**
Colonoscopy/EGD- **MOST RECENT ONLY**
Physical Exam- **MOST RECENT ONLY**
Discharge Summary- **PAST 1 YEAR ONLY**
E.R. Records- **PAST 1 YEAR ONLY**
Progress Notes/Office Notes- **PAST 2 YEARS ONLY**
E.K.G.- **PAST 2 YEARS ONLY**
Laboratory Data- **PAST 2 YEARS ONLY**
XRay, CT, US, MRI, Nuc Med- **PAST 2 YEARS ONLY**

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 federal or state privacy laws and may be re-disclosed by the individual or entity that received this information.
- I understand that I am entitled to a copy of this authorization, upon request
- 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 soley for the purpose of providing health information to someone else and the authorization to make that disclosure.
- 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.

Signature of Patient or Authorized Representative: _____

Printed Name:_____

Date:_____

EXPIRATION DATE: This authorization will expire on (no later thatn one year from today):_____

(If no date, this authorization expires one year from the date it was signed)

-NEWPTREQUEST

AFFIX PATIENT LABEL