NCH north country healthcare

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

PEDIATRIC NEW PATIENT RECORD REQUEST

Pediatric Authorization For Disclosure of Proted 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 over 50 Pages**

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

Physical Exam- **MOST RECENT ONLY**
Lead Testing- **MOST RECENT ONLY**
Hearing & Vision Screenings - **MOST RECENT ONLY**
Immunizations- **ALL DATES**
Growth Charts - **ALL DATES**
Operative Notes- **ALL DATES**
Pathology –**ALL DATES**
Progress Notes/Office Notes- **PAST 2 YEARS ONLY**
Laboratory Data- **PAST 2 YEARS ONLY**
XRay, CT, US, MRI- **PAST 2 YEARS ONLY**
E.K.G.- **PAST 2 YEARS ONLY**
Discharge Summary- **PAST 1 YEAR ONLY**
E.R. Records- **PAST 1 YEAR 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 the federal or stat privacy laws and my be re-disclosed by the individual or entity that received this information.

* I understand 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 dWeeks Medical Center will not condition treatment on providing or refusing to provide this authorization. The only circumstance 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, this authorization expires one year from the date it was signed)

-NEWPTREQUEST

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Reviewed
03/2025

AFFIX PATIENT LABEL