AMOSKEAG HEALTH

CONSENTS

145 Hollis Street . Manchester, NH 03101 . Tel (603) 626-9500
184 Tarrytown Road . Manchester, NH 03104 . Tel (603) 626-9500
1245 Elm Street, Manchester, NH 03101. Tel (603) 668-6629
88 McGregor Street, Suite 302, Manchester, NH 03102. Tel (603)663-5387

PLEASE READ CAREFULLY!

I understand that these consents in its entirety will remain in effect as long as I continue to receive health care services at Amoskeag Health. I understand that if I choose to revoke an Authorized Individual, this must be done in writing to the Business Office Manager. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released based upon this authorization, before Amoskeag Health's receipt of my request to revoke it.

_____ _____

Patient Name **Date of Birth**

Patient / Guarantor Initials

By signing below, I authorize Amoskeag Health to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with, or facilitating the coordination of appointments for me or to assist in coordinating payment for health care services provided to me disclosed in Patient Handbook, **Authorized Representative** on page 18.

Authorized Representative:

Name: _____ **Phone Number**: (_____)_____

Address: _____ **City:** _____ **ST** ____ **Zip** _____

Relationship to Patient: _____

Limitations on Disclosure: _____

Authorized Representative:

Name: _____ **Phone Number**: (_____)_____

Address: _____ **City:** _____ **ST** ____ **Zip** _____

Relationship to Patient: _____

Limitations on Disclosure: _____

By signing below, I authorize another person(s) to **pick up prescriptions or medication** at Amoskeag Health disclosed in Patient Handbook, **Prescription Pick-up Authorization** on page 19.

Authorized Name: _____

Authorized Name: _____

By signing below, I authorize another person(s) to **pick up medical records** at Amoskeag Health disclosed in Patient Handbook, **Medical Records Pick-up Authorization** on page 19.

Authorized Name: _____

Authorized Name: _____

By signing below, I am consenting to allow the providers at Amoskeag Health to provide your child or ward care when you are not present for the following care, treatment and examination disclosed in Patient Handbook, **Parental Consent to Provide Care to a Minor** on page 19. **(Please check ✓ below the type of care you approve)**

Parent/Guardian's Name: _____

Authorized Name: _____

Authorized Name: _____

☐ **Physical Examinations** (School Physicals, Well Child Checks, Camp Physicals, Sport Physicals, etc.)

☐ **Immunizations** ☐ **Sick Care** (Acute illnesses such as colds, flu, or other problems)

☐ **Counseling Services** ☐ **Health Education** ☐ **Female Examinations** (Pap Smears/ Breast Exams)

☐ **Follow-up care for ongoing conditions** (for example: asthma, weight problems, acne, diabetes, and other medical problems)

_____ _____

Signature of Patient, Parent or Legal Guardian **Date**