Authorization for Disclosure of Health Information

Patient Name: **Date of Birth:**

I authorize the following agency/individual to release my protected health information:

☐FROM ☐TO	☐FROM ☐TO
Amoskeag Health **145 Hollis Street** **Manchester NH 03101** **Phone (603) 626-9500** **Fax (833) 448-1486**	Agency:_____ Address:_____ Phone:_____ Fax:_____

- **INFORMATION TO BE RELEASED**:

☐ABSTRACT (includes immunizations, chart summary, office visit notes, lab and diagnostic results for the past 3 years)
☐SPECIFIC DATES: last 18 months of care received at the facility above ☐Other: _____
☐SPECIFIC DOCUMENTS: ☐ Physicals ☐Lab Reports ☐Office ☐Other: _____
☐VERBAL EXCHANGE ☐ENTIRE RECORD (First copy free of charge, subsequent copy $.50 per page)

- **SPECIFIC SENSITIVE DOCUMENTS WILL NOT BE included unless specifically authorized for release by your initials:**___Mental Health /Behavioral Health,___ Alcoholism/ Drug Abuse, ____HIV/AIDS, _____STD's
- **FOR THE FOLLOWING PURPOSE:**

☐Transfer of Care ☐Coordination of Care ☐Consult/Referral/Treatment ☐Personal Copy ☐School/Sports
☐Legal Proceeding ☐Disability Determination ☐Other: _____

- **IF LEAVING OR TRANSFERING CARE TO ANOTHER PRACTICE: PLEASE CHECK REASON(S):**

☐Insurance change ☐Moved/planning to move ☐Location/wanted someplace closer home, ☐Couldn't get appointment ☐My provider left ☐Dissatisfied with care/services-please explain:_____

- **IF INDICATED THAT YOU ARE TRANSFERING /LEAVING AMOSKEAG HEALTH CARE, WE WILL CANCEL ALL FUTURE APPOINTMENTS .YOU WILL BE ELIGIBLE TO ACCESS ACUTE CARE AND MEDICATION REFILLS WITHIN 30 DAYS AFTER THE DATE YOU SIGNED THIS AUTHORIZATION FORM.**

Disclosure of Direct or Indirect Payment received by any person or organization authorized to use or disclose my health information - I understand that Manchester Community Health Center, doing business as Amoskeag Health will **NOT** be receiving any direct or indirect payment in connection with the use or disclosure of my health information.
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Your rights with respect to this authorization:

Right to Inspect or Copy the Health Information to Be Used or Disclosed: I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Medical Records Department or Privacy Officer.

Right to Receive Copy of This Authorization: I understand that I must be provided a copy of this form.

Right to Refuse to Sign This Authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organization listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to not sign this authorization.

Right to Withdraw This Authorization: I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Medical Records Supervisor. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization listed above have already made in reference to this authorization.

NOTE: Protected health information used or disclosed pursuant to this authorization may or may not be subject to re-disclosure by recipient.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. I hereby authorize release of my patient information stated above.

Expiration Date: This authorization is valid one year from the date signed below.

- **Signature of Patient or Guardian:_____Date:_____**

Signature of interpreter who helped with the form(if applicable):_____

For Office Use Only

☐ Faxed ☐ Mailed ☐ Hand Delivered By: _____ Date: _____
Staff Name