Whole Person. Whole Family. Whole Valley.
298 White Mt. Hwy • PO Box 2800 • Conway, NH 03818 • 603-447-8900

Patient's Authorization for Release of Information from White Mountain Community Health Center

Patient Name: ____ DOB: ________________

I authorize White Mountain Community Health Center to disclose information to:

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For the Purpose of:

___ Transfer of Care (leaving this facility)
___ Consultation/Referral
___Continuation of Care
___ Other:

Information requested:

___ All Records
___ History & Annual/Physical
___ Laboratory
___ Progress Notes
___ Discharge Summary
___ Consultation
___ Other :

- **I understand that this authorization may be revoked in writing and delivered to WMCHC at any time, although revocation will not be effective as to the disclosure of records previously authorized and shared.**
- **I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining authorization and that I MAY REFUSE TO SIGN THIS AUTHORIZATION.**
- **I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.**

____ ________________
Signature of Patient or Representative **Date**

____
Authority or Relationship of Representative
Expiration Date: This authorization will expire one calendar year from the signature date.

*****SPECIAL AUTHORIZATION*****

Drug/Alcohol Abuse, Mental Health Information and/or AIDS Information
I acknowledge that data to be released MAY INCLUDE material that is protected by federal law and that is applicable to one or more above. My signature below authorizes release of all such information.

____ ________________
Signature of Patient or Representative **Date**

____
Authority or Relationship of Representative