



WHITE MOUNTAIN COMMUNITY HEALTH CENTER

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 to White Mountain Community Health Center

Patient Name: _____ DOB: _____

I authorize:

to disclose information to:

White Mountain Community Health Center, P.O. Box 2800, 298 White Mountain Highway, Conway, NH 03818

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