AUTHORIZATON TO RELEASE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

WHITE MOUNTAIN COMMUNITY HEALTH CENTER
Whole Person. Whole Family. Whole Valley.

PATIENT INFORMATION	Name: _____ Date of Birth: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip: _____
WHO has the information you want released? *Please include essential info needed to contact the right location*	☐ Name: _____ Address: _____ City: _____ State: _____ Phone: _____ Fax: _____ **OR** ☐ **White Mountain Community Health Center, Conway, NH 03818 Phone: 603-447-8900 Fax: 603-447-4846** I hereby authorize the above named healthcare office to: ☐ **Release medical records to** ☐ **Speak/discuss with** ☐ **BOTH release medical records to and discuss medical information with**
WHO do you want to receive your records?	☐ **White Mountain Community Health Center, Conway, NH 03818 Phone: 603-447-8900 Fax: 603-447-4846** **OR** ☐ Name: _____ Address: _____ City: _____ State: _____ Phone: _____ Fax: _____
INFORMATION TO BE RELEASED **WHAT** do you want shared? **CHECK** the appropriate boxes.	**Indicate date(s) of service to be included: FROM: _____ TO: _____** **Type of information to release:** ☐ Entire medical record ☐ Immunization record ☐ Most recent history and physical ☐ Verbal exchange of information ☐ Laboratory reports ☐ Radiology/imaging reports ☐ Genetic testing ☐ Dental chart ☐ Dental X-rays ☐ Other: _____ ☐ Consultations ☐ ER notes ☐ Surgical report ☐ Discharge summary ☐ Psychiatric evaluation ☐ Psychiatric notes ☐ Therapy notes ☐ Substance use disorder diagnosis/treatment ☐ HIV diagnosis/treatment **Authorization to Release Protected Information** ☐ **I DO** authorize disclosure of any information relating to substance use disorder ☐ **I DO NOT** ☐ **I DO** authorize disclosure of any information relating to mental health diagnosis and/or treatment ☐ **I DO NOT** ☐ **I DO NOT** want to review mental health information before it is sent ☐ **I DO WANT TO** ☐ **I DO** authorize disclosure of information which refers to HIV infection status and/or treatment ☐ **I DO NOT** ☐ I understand that my substance use disorder treatment records are protected under Title 42 of the Code of Federal Regulations (CFR) Part 2: Confidentiality of Substance Use Disorder Patient Records and the HIPAA 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and in the event that this consent expires automatically as follows (*Specify the date, event or condition upon which this consent expires, if any*):_____.
PURPOSE OF RELEASE Why is this info needed?	☐ Continuing care ☐ Transfer of care ☐ Personal use ☐ Legal purposes ☐ Worker's compensation claim ☐ Other: _____ **Fees may be charged in accordance with state and federal statutes**

I understand that:

- ☐ I can revoke all or part of this authorization at any time by notifying White Mountain Community Health Center in writing that no future disclosures should be made. This will not affect any protected health information that has already been released under this authorization.
- ☐ I can refuse to disclose some or all of the information in my record, but refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences.
- ☐ If protected health information is disclosed to a third party, the information may no longer be protected by federal or state privacy laws and may be re-disclosed by the individual or entity that receives this information.
- ☐ I am entitled to a copy of this authorization, upon request.

Accessing and obtaining your medical records is a requirement under 45 CFR 164.524 which requires that any request made to access or transfer medical records must be completed within **30 days** or a letter must be sent to the requestor stating why the records are delayed.

This authorization is effective for **1 year** from the date of signing. I authorize future disclosures to the same individual and/or entity of the same record set during this time pursuant to this authorization.

Signature: _____ **Date:** _____

Printed name of person signing (if not patient): _____

Relationship of authorized representative (e.g. parent, guardian, power of attorney): _____