NCH north country healthcare | Androscoggin Valley Hospital

Authorization For Release Of Information

Please complete all sections. Missing information may cause delays or the inability to retrieve your records. Release may take up to 30 days to process.

59 Page Hill Road
Berlin, NH 03570
Phone: 603-752-2200

Please Print Patient Information *must be fully completed*

Name: _____ Previous name: _____ Date of Birth _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

***Who** has the information you want released.*

Please list the specific hospital, physician office and/or home health agency

Provider: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____ Fax: _____

Who *do you want to receive your information*

I hereby authorize the above-named hospital/physician office to:

❑ Release medical records, to ❑ Speak to/discuss with, ❑ Both release medical records to and discuss medical information with,

Name: _____ Attention to: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____ Fax: _____

Date(s) of service From: _____ To: _____

Information to be released:

What *do you want shared? Check appropriate boxes*

Description of information to be released: (check all that apply)

____ Discharge Summary	____ Laboratory Report	____ Physician Orders	____ Cardiology
____ Emergency Dept	____ Radiology Report	____ Rehab PT/OT/ST	____ X-ray films/CD
____ Urgent Care	____ Pathology	____ Chart Summary	____ Billing records
____ History & Physical	____ Operative Reports	____ Progress Notes/Office notes	
____ Abstract (summary of visits and all tests)		____ Consultations	___ Immunizations

____Other_____

Sensitive Information (**INITIAL** to be released)

____ Drug and Alcohol testing and/or treatment Records	____ HIV/AIDS/STD testing and/or treatment Records
____ Psychiatric Evaluation	____ Mental Health Progress Notes
____ Treatment Plan	____ Medication History
____ Intake Assessment	____ Evaluations

Purpose of release *(Why is it needed)*

❑Continuing Care ❑ Transfer of Care ❑ Personal Use/Review ❑ Insurance ❑ Workers Compensation

❑ Attorney ❑Temporary Transfer of care (school/winter away) ❑ Other (specify): _____

Fees may be charged in accordance with State and Federal Statutes

FOR LEGAL USE ONLY

Discussion/Testimony/Affidavits: I authorize the following individuals to discuss with me and/or _____ and to give sworn affidavits as to whatever s/he knows about my illness, injuries and treatment, as referenced on this form.

_____any and all practitioners _____Other Staff _____Other: _____

I understand that:

- ❑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
- ❑I can revoke all or part of this authorization at any time during this time period by providing written notice to the Health Information Management Department, **except** where this authorization already has been acted on for release of my protected health information. Such revocation may be the basis for denial of health benefits of other insurance coverage or benefits
- ❑I understand that if protected health information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be re-disclosed by the individual or entity that receives this information
- ❑I understand I am entitled to a copy of this authorization, upon request
- ❑ If any of the information disclosed pursuant to this request is from records protected by Federal confidentiality rules at 42 CFR Part 2, those rules prohibit the recipient from making any further disclosure of this information unless I expressly permit it through my written consent or redisclosure is performed as otherwise permitted in 42 CFR Part 2.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____
I understand that if I fail to specify an expiration date, event or condition, this authorization will expire 6 months from date signed. I also understand it is my responsibility if I document a long expiration date to cancel in writing to Androscoggin Valley Hospital I wish to change.

Signature of Patient or Authorized Representative _____

Printed Name _____

Relationship of Authorized Representative (e.g. Parent, Guardian, Power of Attorney) _____

Date _____ **Time** _____

FOR OFFICE USE ONLY

Medical Record # _____
Visit ID _____
Telephone request ( ) Date:_____
Charge: Yes Or No
By Whom: _____
Info to be ( ) Faxed ( ) Mailed ( ) Picked up ( ) Handed
Date/Time to be mailed, etc: _____
Date Completed: _____