NORTH COUNTRY HEALTHCARE
AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION
You may tear off this page and retain it for your records.

By signing this authorization, you are permitting the use and/or disclosure of your health information for the limited purpose(s), and in the limited manner, described in this form. Except as authorized by this form, we are required by federal law to maintain the privacy of your health information as described in our Notice of Privacy Practices.

Refusals of Service
If the only reason you have asked us to provide a health care service is so that we can create information to be disclosed to a third party, we may refuse to provide the service if you refuse to sign this authorization. For example, if you have requested a drug test solely for the purpose of having the results disclosed to your employer, we may refuse to perform the drug test if you refuse to sign this authorization permitting us to disclose the results to your employer.

Otherwise, your ability to receive treatment, payment, enrollment in a plan, or eligibility for a benefit does not depend on your signing this form. **You may refuse to sign this form.**

(Note to Workforce Members Presenting this Form: If the treatment of the patient, payment for the patient's care, or enrollment of the patient in a health plan is conditioned on the patient signing this form, no use or disclosure other than that upon which treatment, payment, or enrollment has been conditioned can be authorized on this form. A separate authorization would be needed for any other use or disclosure.)

Consequences of Signing this Form
Signing this authorization may cause the health information used or disclosed pursuant to this authorization to no longer receive the protections of federal privacy laws. Any person or organization to whom your health information is disclosed pursuant to this authorization might be able to legally re-disclose that information to others.

Revocation
You may revoke this authorization at any time, in writing, except to the extent that we have already relied upon it in making a use or disclosure. Your written revocation will become effective when we have knowledge of it. If you are providing this authorization to obtain insurance coverage, you may not have the right to revoke the authorization to the extent that it pertains to the insurer's right under law to contest a claim under your insurance policy. If you wish to revoke this authorization, please send your written request to: Privacy Officer, North Country Healthcare, 59 Page Hill Road, Berlin, NH, 03570.

Expiration
Once this authorization has expired, we will no longer use or disclose your health information for the purpose listed in this authorization unless you sign a new authorization form.

NCH north country healthcare

Authorization for Release of Information

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

AVH Fax: 603-326-5832	Phone: 603-326-5655
UCVH Fax: 603-237-4145	Phone: 603-388-4300
Weeks Fax: 603-788-5031	Phone: 603-788-5636
NCHHHA Fax: 603-444-0980	Phone: 603-444-5317

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

❑ Androscoggin Valley Hospital, 59 Page Hill Road, Berlin, NH 03570

❑ Indian Stream Health Clinic, 181 Corliss Lane, Colebrook, NH 03576

❑ Upper Connecticut Valley Hospital, 181 Corliss Lane, Colebrook, NH 03576

❑ Weeks Medical Center, 173 Middle Street, Lancaster, NH 03584

❑ North Country Home Health & Hospice Agency, 536 Cottage Street, Littleton, NH 03561

❑ Other Facilty/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 as described below:

Name: ____________________ Attention to: __________

Address: ____________________ Phone: __________

City: __________ State: ________ Zip Code: ________ Fax: __________

Information to be released:

What *do you want shared? Check appropriate boxes*

Date(s) of service From: ____________________ To: __________

We do not accept "ALL" for date of service, if left blank the last 2 years will be sent.

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

❑ Discharge Summary	❑ Laboratory Report	❑ Physician Orders	❑ Cardiology/EKG
❑ Emergency Dept	❑ Radiology Report	❑ Rehab PT/OT/ST	❑ X-ray films/CD
❑ History & Physical	❑ Pathology	❑ Consultations	❑ Billing records
❑ Operative Reports	❑ Medication Lists	❑ HH/Care Plan	❑ Immunizations
❑ Progress Notes/Office notes		❑ HH/Treatment notes	
❑ Other ______________		❑ Abstract (summary of visits and all tests)	

Sensitive Information 42 CFR Part 2 (**INITIAL all that apply**)

____ Drug and Alcohol Testing	____ HIV/AIDS/STD Testing
____ Drug and Alcohol Treatment Records	____ HIV/AIDS/STD Treatment Records
____ Psychiatric Evaluations	____ Mental Health Progress Notes
____ Treatment Plan	____ Medication List
____ Intake Assessment/Screening	

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

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 1 year from date signed, unless revoked in writing.

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: _______________________________