Mid-State Health Center

Authorization to Release Patient information **TO** Mid-State Health Center

Patient Name:_____ Date of Birth:_____

Release Previous Medical Records From (Organization/Provider):

Name of Organization/Provider: _____

_____

Address City State Zip

Telephone Number:_____ Fax Number:_____

to disclose the above named individual's health information as described below: ☐ VERBAL ONLY ☐ RECORDS ONLY ☐ BOTH

Date(s) of Service Requested (if known):_____

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

☐ Entire medical record	☐ Verbal exchange of information	☐ Progress notes
☐ Immunization record	☐ Most recent history and physical	☐ Behavioral Health treatment & evaluation records
☐ Laboratory reports	☐ Consultations	☐ Copy of dental chart
☐ Radiology/Imaging reports		☐ Copy of dental x-rays

☐ Other _____

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome ("AIDS"), or Human Immunodeficiency Virus ("HIV"), or genetic testing. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization:

Mid-State Health Center
101 Boulder Point Drive Suite 1
Plymouth, NH 03264
Phone Number (603) 536-4000 Fax Number (603) 536-4001

**If there are fees associated with this request, please contact our office prior to processing.*

Description of purpose of the use and/or disclosure:

☐ Continuing care	☐ Second opinion	☐ Personal Use
☐ Consultation	☐ Insurance	☐ ARCHIVE FILES
☐ Legal purposes	☐ Social Security/Disability	

☐ Other: Please describe_____

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify.
This authorization will be in effect until _____ (date or event).

I understand that I may revoke this authorization at any time by notifying the facility from which I am requesting my health information. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed Name of Patient or Patient's Representative

_____ or _____
Relationship to Patient Legal Authority (attach supporting documents)