Mid-State Health Center

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

Patient Name:_____ Date of Birth:_____

I hereby authorize

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

to disclose the above-named individual's health information as described below:

Should we cancel any future appointments you may have previously scheduled? ☐ Yes ☐ No

Reason for transfer:_____

_____

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

In order to be more environmentally responsible we no longer offer paper copies of records. Records will be put on CD in Adobe PDF format.

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"), behavioral or mental health, alcohol/drug abuse, genetic testing or any such related information.

This information may be disclosed to and used by the following individual or organization: (*fill in where you would like records sent*)

_____ _____ _____ _____ _____

Name Address City State Zip

Telephone Number_____ Fax Number_____

Description of purpose of the use and/or disclosure:

☐ Continuing care	☐ Second opinion	☐ Personal use
☐ Consultation	☐ Insurance	
☐ 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 Mid-State Health Center may charge a processing fee for this service, and that I may be responsible for payment of this charge. 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 Medical Information Management Department at Mid-State Health Center. 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)

(1/2015)