Mid-State Health Center:
Authorization to Release/ Disclose Protected Health Information

Patient Name: ____ **DOB:** ______________

Instructions: Complete all applicable sections to have information disclosed **FROM** or **TO** Mid-State Health Center (MSHC). Refusal to complete this form will not affect the quality of or access to care, condition of treatment, payment, enrollment or eligibility for benefits.

Patient Notice – This Section Applies to All Requests

Note: This is a required section and must be completed in its entirety.

______ I hereby authorize to disclose/ release my protected health information (PHI) orally or in writing **FROM**:

☐ Mid-State Health Center
101 Boulder Point Dr Suite 1
Plymouth, NH 03264
(P)603-536-4000 (F)603-536-4001

☐ ____
Organization Name:
____
Address:
____________________ ____________________
Phone # Fax #

(Check all that apply) ☐ Medical ☐ Behavioral Health ☐ Dental ☐ IOP/Substance Use Disorder ☐ **All**

A. I request that the information be released for the following purpose: (**Initial** all that apply)

_____ Transfer of Care
_____ Continuing Care
_____ Personal Use
_____ Disability
_____ Attorney/ Legal
_____ School
_____ Military
_____ Billing or Claims
_____ Insurance
_____ Financial Aid
_____ Self-Pay
_____ Review Request
_____ Other: ________________

B. I request that the information be released **TO**:

☐ Mid-State Health Center, 101 Boulder Point Dr Suite 1, Plymouth NH 03264 (P) 603-536-4000 (F) 603-536-4001

☐ Name/ Facility Name: ______________________________ Attn: ______________________________
Address: ______________________________City/ State: ____________________ Zip Code: __________
Phone: ______________________ Email: ______________________________ Fax: ______________________

☐ Name/ Facility Name: ______________________________ Attn: ______________________________
Address: ______________________________City/ State: ____________________ Zip Code: __________
Phone: ______________________ Email: ______________________________ Fax: ______________________

C. All **record requests** will be delivered in an electronic format (CD or via electronic file portal), unless otherwise specified. Please initial requested delivery method:

_____ Electronic File (CD) _____ Other: ________________ _____ In Office Pick-Up (valid photo ID required)*

*To retrieve this information in person, a valid photo ID will be required for patient privacy and confidentiality purposes.

*I understand that a processing **fee may apply** for the requested information.

_____ I understand that my medical record may be incomplete and that additional documentation may be added when received

Records requested are in an electronic format (e.g. CD) unless paper specified above. Electronic signatures are not accepted.

☐ **MEDICAL Records – Initial ONLY Items That Apply**

A. Information to be released:

_____ **Complete Medical Record**
_____ Office Visit Notes
_____ Consultation Reports
_____ History & Physical
_____ Immunizations
_____ Other: ______________________________
_____ Implant Records
_____ Laboratory
_____ Medication Lists
_____ Pathology Report
_____ Psychiatry
_____ X-Ray(s)
_____ Ultrasound/Sonogram
_____Images ONLY
_____ Reports ONLY
_____ Explanted Materials, Devices, Hardware
_____ Billing Records
_____ Demographics
_____ Family Studies

B. Time period or date of information to be released: (MM/YY) From: ____________________ To: ____________________

C. Specific Treating Provider Name(s): ____ OR _____ All Medical Providers

D. Specific Clinic/ Service(s): ____ OR _____ All Medical Services

☐ **DENTAL Records- Initial ONLY Items That Apply**

A. Information to be released:

_____ All Dental Records _____ Dental Images (XRays) _____ Dental Office Notes

B. Time period or date of information to be released: (MM/YY) From: ____________________________ To: ______________________________

C. Specific Treating Provider Name(s): ____ OR _____ All Providers

☐ **BEHAVIORAL HEALTH Records – Initial Only Items that Apply**

A. Information to be released:

_____ All Behavioral Health Records _____ Specific Provider: ___________________________

B. Date(s) of information to be released (MM/YY): From _________________ To: __________________

_____ **I understand that psychotherapy notes will not be included unless authorized under 45 CFR 164.508(a)(2).**

IOP/SUBSTANCE USE DISORDER – Initial Only Items That Apply

****** Must complete Authorization to Disclose Substance Use 42 Part 2 Form ******

Patient Acknowledgement – This Section Applies to All Requests

This authorization form does not authorize the release of Substance Use Therapy Records. A separate Authorization to Disclose Substance Use 42 Part 2 Form must be completed.

- ❖ I understand that the information in my health record may include information relating or referencing: Genetic counseling; Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) treatment; history of drug or alcohol abuse; mental, behavioral health, or psychiatric care; and/or other sensitive information.
- ❖ I understand that I may revoke this authorization in writing at any time, except to the extent that MSHC has relied on this authorization. The written revocation should be addressed to the Health Information Management Department. Unless otherwise revoked, I understand that the date upon which this authorization **expires is 180 days** unless otherwise specified _______________.
- ❖ I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA).

______________________________	______________________________	______________________
Patient's Printed Name:	Patient's Signature:	Date:
______________________________	______________________________	______________________
*Legal Representative's Printed Name:	Legal Representative's Signature	Date:

***Note: Proof of legal authority may be required for legal representatives**

<u>**Return Form to:**</u> **Mid-State Health Center**
Health Information Management – Release of Information
101 Boulder Point Drive, Suite 1
Plymouth, NH 03264
Phone: 603.536.4000 **Fax**: 603.536.4001
Email: medicalrecords@midstatehealth.org