MID-STATE HEALTH CENTER

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

Patient Name: _____ **DOB:** _____

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

1. Who is permitted to send and receive your personal health information?

	Name:	Address:	Phone #	Fax #
☐ **FROM:** ☐ **TO:**	Mid-State Health Center	101 Boulder Point Dr, Suite 1 Plymouth, NH 03264	603-536-4000	603-536-4001
☐ **FROM:** ☐ **TO:**				

2. What records would you like to share?

(Check all that apply) ☐ Medical ☐ Behavioral Health ☐ Dental ☐ Physical Therapy

A. Type of information to be released:

_____ Office Visit Notes _____ Immunizations _____ Laboratory _____ Medication Lists

_____ Radiology Reports & Images _____ Other:_____

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

3. Why is this information being released?

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

_____ Transfer of Care _____ School _____ Attorney/ Legal * _____ Insurance/Billing/Financial

_____ Continuing Care _____ Disability _____ Personal Use _____ Other: _____

B. All **record requests** will be delivered via fax or mail unless otherwise specified. Please initial requested delivery method:

_____ In Office Pick-Up (valid photo ID required) _____ Patient Portal _____ Encrypted Email _____ Other: _____

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

4. Patient Acknowledgement

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. **Psychotherapy notes will not be included unless authorized by provider under 45 CFR 164.508(a)(2).**

- I understand that the information in my health record may include information relating to 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:

(Proof of legal authority may be required)

Return Form To: **Mid-State Health Center – Release of Information**

101 Boulder Point Dr, Suite 1, Plymouth, NH 03264

Phone: 603-536-4000 x1500, **Fax:** 603-536-4001, **Email:** medicalrecords@midstatehealth.org