GREATER SEACOAST COMMUNITY HEALTH

LILAC CITY PEDIATRICS

Lilac City Pediatrics
180 Farmington Rd., Rochester NH 03867
Ph: 603-335-4522 Fax: 603-335-8631

RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Phone(s): _____

I authorize Lilac City Pediatrics to release personal health information of the above-named individual to the person or facility named below, or to obtain information from that person/facility. ☐ **Release to** ☐ **Obtain from**

Name/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

City, State, Zip: _____ Email: _____

For dates of care from: _____ to: _____

Purpose of release: _____

If leaving our practice, reason: _____

Please *initial*, at left, all types of information that you authorize us to release or obtain:

__ __ Medical diagnostic, testing, and treatment information
__ __ Dental diagnostic, testing and treatment information and /or x-rays taken: _____
__ __ Records of immunizations and physicals
__ __ Current prenatal records, copies of all lab tests (including HIV results) and/or scans
__ __ Summary of labor and delivery notes for the following date of delivery: _____
__ __ Information about Sexually Transmitted Diseases and/or HIV/AIDS
__ __ Psychiatric/psychological evaluation(s), reports, assessments, summaries, psychotherapy notes or other documents with diagnosis, prognoses, recommendations, or testing records and behavioral observations.
__ __ Drug and alcohol information including evaluation, diagnostic, treatment and progress notes.
__ __ Other: _____

Methods of Disclosure Authorized: Faxed, written, phone conversation, in-person and/or secure e-mail

- I understand that I may revoke (withdraw) this authorization at any time by notifying Families First in writing. Revocation will be effective as of the date received.
- I understand that a revocation will not apply to: 1) any actions that Families First has already taken while relying on this authorization before I revoke it; or 2) if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that I might be denied services if I refuse to consent to disclosure for purposes of **treatment, payment, or health care operations**, if permitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes.
- I understand that the recipient of some information disclosed under this authorization may re-disclose this information and that the information will no longer be protected by federal privacy regulations.
- I understand that I have the right to: 1) Inspect or copy the protected heath information to be used or disclosed as permitted under Federal law; 2) Refuse to sign this authorization.
- This authorization will remain in effect **for one year** and may be revoked at any time in writing.
- Unless otherwise noted, only the **past two years** of electronic records as stipulated above will be sent.

Signature of Patient and/or Legal Representative: _____ **Date:** _____

***To receiving provider**: This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

For office use only: Witness: _____ Date: _____

Sent by: _____ Date: _____