GREATER SEACOAST COMMUNITY HEALTH

Goodwin Community Health | Families First | Lilac City Pediatrics

# Release of Medical Information

Patient Name: _____ Date of Birth: _____

Phone(s):_____

**I request that documents be released to Greater Seacoast Community Health at the following practice:**

- ❒ **Families First Health & Support Center,** 8 Greenleaf Woods Dr., Portsmouth, NH 03801 | (603) 422-8208 | Fax (603) 422-8218
- ❒ **Goodwin Community Health,** 311 Route 108, Somersworth, NH 03878 | (603) 749-2346 | Fax (603) 749-2748
- ❒ **Lilac City Pediatrics,** 311 Route 108, Somersworth, NH 03878 | (603) 749-2346 | Fax (603) 749-2748

**I authorize Greater Seacoast Community Health to release the patient's personal health information to the facility or person named below, or to obtain it from the person or 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 the practice in writing. Revocation will be effective as of the date received.
- I understand that a revocation will not apply to: 1) any actions that this practice 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 by notifying this practice 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: _____