Upper Connecticut Valley Hospital

Authorization For Release Of Information

Please complete all sections. Missing information may cause delays or the inability to retrie[ve]
Release may take up to 30 days to process.

181 Corliss Lane
Colebrook, NH 03576
Phone: 603-388-4300
Fax: 603-237-4145

Please Print Patient Information *must be fully completed*	Name: ____________ Previous name: ____________ Date of Birth ____________ Address: ____________ Phone: ____________ City: ____________ State: ____________ Zip Code: ____________
Who *has the information you want released.* **Please list the specific hospital, physician office and/or home health agency**	❑Upper Connecticut Valley Hospital, 181 Corliss Lane, Colebrook, NH 03576 Provider: ____________ Address: ____________ Phone: ____________ City: ____________ State: ____________ Zip Code: ____________ Fax: ____________
Who *do you want to receive your information*	I hereby authorize the above-named hospital/physician office to: ❑ Release medical records, to ❑ Speak to/discuss with, ❑ Both release medical records to and discuss medical information with, Name: ____________ Attention to: ____________ Address: ____________ Phone: ____________ City: ____________ State: ____________ Zip Code: ____________ Fax: ____________
Information to be released: **What** *do you want shared? Check appropriate boxes*	Date(s) of service From: ____________ To: ____________ Description of information to be released: (check all that apply) ____ Discharge Summary ____ Laboratory Report ____ Physician Orders ____ Cardiology ____ Emergency Dept ____ Radiology Report ____ Rehab PT/OT/ST ____ X-ray films/CD ____ Urgent Care ____ Pathology ____ Chart Summary ____ Billing records ____ History & Physical ____ Operative Reports ____ Progress Notes/Office notes ____ Abstract (summary of visits and all tests) ____ Consultations ____ Immunizations ____Other____________ **Sensitive Information** (**INITIAL** to be released) ____ Drug and Alcohol testing and/or treatment Records ____ HIV/AIDS/STD testing and/or treatment Records ____ Psychiatric Evaluation ____ Mental Health Progress Notes ____ Treatment Plan ____ Medication History ____ Intake Assessment ____ Evaluations
Purpose of release *(Why is it needed)*	❑Continuing Care ❑ Transfer of Care ❑ Personal Use/Review ❑ Insurance ❑ Workers Compensation ❑ Attorney ❑Temporary Transfer of care (school/winter away) ❑ Other (specify):____________ **Fees may be charged in accordance with State and Federal Statutes**

I understand that:

- ❑I can refuse to disclose some or all of the information in my record, but refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences
- ❑I can revoke all or part of this authorization at any time during this time period by providing written notice to the Health Information Management Department, **except** where this authorization already has been acted on for release of my protected health information. Such revocation may be the basis for denial of health benefits of other insurance coverage or benefits
- ❑I understand that if protected health information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be re-disclosed by the individual or entity that receives this information
- ❑I understand I am entitled to a copy of this authorization, upon request
- ❑ If any of the information disclosed pursuant to this request is from records protected by Federal confidentiality rules at 42 CFR Part 2, those rules prohibit the recipient from making any further disclosure of this information unless I expressly permit it through my written consent or redisclosure is performed as otherwise permitted in 42 CFR Part 2.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition:____________________
I understand that if I fail to specify an expiration date, event or condition, this authorization will expire 6 months from date signed. I also understand it is my responsibility if I document a long expiration date to cancel in writing to Upper Connecticut Valley Hospital I wish to change.

Signature of Patient or Authorized Representative ____

Printed Name ____

Relationship of Authorized Representative (e.g. Parent, Guardian, Power of Attorney) ______________________________

Date _________________________________ **Time** _______________________

FOR OFFICE USE ONLY

Medical Record # __________________
Visit ID ___________________________
Telephone request ( ) Date:_________
Charge: Yes Or No
By Whom: __________________________________
Info to be ( ) Faxed ( ) Mailed ( ) Picked up ( ) Handed
Date/Time to be mailed, etc: ____________________
Date Completed: _______________________________