

ACHS - Littleton

25 Mount Eustis Road Littleton, NH 03561

6034442464 Fax: 6034445209

Website: www.ammonoosuc.org

Authorization for Release of Information

Patient's Name:

DOB:

Release Information To:

Receive Information From:

I hereby authorize and request the exchange of information (verbally or in writing) between Ammonoosuc Community Health Services and the above mentioned individual/organization. The following information is requested to be shared:

Office Notes

Medication List

Immunizations

Laboratory Results

Chart Summary

Imaging Reports

Pathology Reports

Prescription Information

Consultation Reports

Diagnostic Reports

Hospital Correspondence

Social Work Reports

Internal Correspondence

External Correspondence

Previous Medical Records

Other: _____

The purpose of this release is to expedite: Transfer of Care Sharing of Care

Dates: From: _____ To: _____

Release of confidential information is subject to State and Federal laws. By signing this release, I acknowledge my permission to release the above information to and/or from the individual or agency I have named which may include drug and alcohol abuse information.

Note: Federal regulations govern the confidentiality of alcohol and drug dependent persons. (42 CFR Part 2). Federal law prohibits the disclosure of (1) psychotherapy notes; (2) information compiled in reasonable anticipation of, or for the use in civil, criminal, or administration action or proceedings.

I understand I may revoke this authorization at any time by notifying ACHS in writing, except to the extent that: a) action has been taken in reliance on this authorization; or b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand I have the right to request and receive a Notice of Privacy Practices from ACHS.

All releases expire one year from the date signed unless otherwise indicated.

I hereby authorize the following: (please initial if applicable)

_____ Disclosure of the results of HIV antibody blood testing and/or information concerning AIDS (Acquired Immune Deficiency Syndrome).

Signature of patient or patient's representative

Relationship

Witness: _____

Date: _____

Prohibition of Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.