

Manchester Community Health Center at CHS  
 1245 Elm Street  
 Manchester, NH 03101  
 Phone: 603-668-6629  
 Fax: 603-626-9523

**Authorization for Disclosure of Health Information**

<b>Patient Name:</b>	<b>Date of Birth:</b>
<b>I authorize the following agency/individual to release my protected health information:</b>	
<input type="checkbox"/> FROM <input type="checkbox"/> TO <b>Manchester Community Health Center</b> 145 Hollis Street Manchester NH 03101 Phone (603) 626-9500 Fax (603) 626-9523	<input type="checkbox"/> FROM <input type="checkbox"/> TO Agency: _____ Address: _____ Phone: _____ Fax: _____
<p>❖ <b>INFORMATION TO BE RELEASED:</b></p> <input type="checkbox"/> ABSTRACT (includes immunizations, chart summary, office visit notes, lab and diagnostic results for the past 3 years) <input type="checkbox"/> SPECIFIC DATES: last 18 months of care received at the facility above <input type="checkbox"/> Other: _____ <input type="checkbox"/> SPECIFIC DOCUMENTS: <input type="checkbox"/> Physicals <input type="checkbox"/> Lab Reports <input type="checkbox"/> Office <input type="checkbox"/> Other: _____ <input type="checkbox"/> VERBAL EXCHANGE <input type="checkbox"/> ENTIRE RECORD (First copy free of charge, subsequent copy \$.50 per page) <p>❖ <b>SPECIFIC SENSITIVE DOCUMENTS WILL NOT BE included unless specifically authorized for release by your initials:</b> ___ Mental Health /Behavioral Health, ___ Alcoholism/ Drug Abuse, ___ HIV/AIDS, ___ STD's</p> <p>❖ <b>FOR THE FOLLOWING PURPOSE:</b></p> <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Coordination of Care <input type="checkbox"/> Consult/Referral/Treatment <input type="checkbox"/> Personal Copy <input type="checkbox"/> School/Sports <input type="checkbox"/> Legal Proceeding <input type="checkbox"/> Disability Determination <input type="checkbox"/> Other: _____ <p>❖ <b>IF LEAVING OR TRANSFERING CARE TO ANOTHER PRACTICE: PLEASE CHECK REASON(S):</b></p> <input type="checkbox"/> Insurance change <input type="checkbox"/> Moved/planning to move <input type="checkbox"/> Location/wanted someplace closer home, <input type="checkbox"/> Couldn't get appointment <input type="checkbox"/> My provider left <input type="checkbox"/> Dissatisfied with care/services-please explain: _____ <p>❖ <b>IF INDICATED THAT YOU ARE TRANSFERING /LEAVING MCHC CARE, WE WILL CANCEL ALL FUTURE APPOINTMENTS .YOU WILL BE ELIGIBLE TO ACCESS ACUTE CARE AND MEDICATION REFILLS WITHIN 30 DAYS AFTER THE DATE YOU SIGNED THIS AUTHORIZATION FORM.</b></p> <p><b>Disclosure of Direct or Indirect Payment</b> received by any person or organization authorized to use or disclose my health information - I understand that <u>Manchester Community Health Center</u> will <b>NOT</b> be receiving any direct or indirect payment in connection with the use or disclosure of my health information. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR 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 CFR part 2. A general authorization for the release of medical or other information is <b>NOT</b> sufficient for this purpose.</p> <p><i>Your rights with respect to this authorization:</i></p> <p><b>Right to Inspect or Copy the Health Information to Be Used or Disclosed:</b> I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Medical Records Department or Privacy Officer.</p> <p><b>Right to Receive Copy of This Authorization:</b> I understand that I must be provided a copy of this form.</p> <p><b>Right to Refuse to Sign This Authorization:</b> I understand that I am under no obligation to sign this form and that the person(s) and/or organization listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to not sign this authorization.</p> <p><b>Right to Withdraw This Authorization:</b> I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Medical Records Supervisor. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization listed above have already made in reference to this authorization.</p> <p><b>NOTE:</b> Protected health information used or disclosed pursuant to this authorization may or may not be subject to re-disclosure by recipient.</p> <p>I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. I hereby authorize release of my patient information stated above.</p> <p><b>Expiration Date:</b> This authorization is valid one year from the date signed below.</p> <p>❖ <b>Signature of Patient or Guardian:</b> _____ <b>Date:</b> _____</p> <p>Signature of interpreter who helped with the form( if applicable): _____</p>	
<i>For Office Use Only</i>	
<input type="checkbox"/> Faxed <input type="checkbox"/> Mailed <input type="checkbox"/> Hand Delivered    By: _____    Date: _____ <div style="text-align: center;">Staff Name</div>	