COOS COUNTY FAMILY HEALTH SERVICES, INC./COOS COOUNTY FAMILY DENTAL

- Coos County Family Health Services, 133 Pleasant Street, Berlin, NH 03570, (603) 752-2040, fax: 752-7797
- Coos County Family Health Services, 59 Page Hill Road, Berlin, NH 03570, (603) 752-2900, fax: 752-3727
- Coos County Family Health Services, 2 Broadway Street, Gorham, NH 03581, (603) 466-2741, fax: 466-2953
- Coos County Family Health Dental, 73 Main St., Berlin, NH 03570, (603) 752-2424, fax: 752-2436
- Coos County Family Health, 6 First Street, Colebrook, NH 03576, (603)-237-4262, fax: (603) 237-8401

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

Address:_____ Phone Number:_____
(Street, City and State) Cell Phone Number:_____

( ) Health Records/Information from_____(Date) to_____(Date) or ☐ Past 3 Years.

☐ All Records (3 Years) ☐ Emergency Department report ☐ Provider office note
☐ Physical exam letter/form ☐ Immunization records ☐ Radiology report
☐ Chart Summary (initial below) ☐ Laboratory report ☐ Dental
- Other: _____

( ) No limitations placed on history of illness with diagnostic and therapeutic information including HIV testing or disease, substance abuse, psychiatric care or mental health information and genetic testing.
(Patient must initial if this item is checked) Initials:_____

() No limitation placed on psychotherapy notes/communication. Initials _____ ☐ Past 3 Years.

(** Must check and initial for <u>Behavioral Health Records</u>)

Understand
- I may revoke this authorization at any time, except to the extent CCFHS has already authorized disclosures.
- CCFHS may not condition treatment on my willingness to sign this authorization.
- If the entity to which I have authorized disclosure is not a health care provider or health plan subject to the Federal Privacy Rule, the information could be disclosed to other parties without being protected by the Privacy Rule.

The undersigned hereby authorizes CCFHS to disclose my health care record/information to:

Facility Name:_____

Address:_____

Phone Number:_____ Fax Number:_____

Purpose of disclosure:_____

This authorization shall expire 1 year from the date of signing. A photocopy of this authorization shall be accepted with the same authority as the original.

Print Name:_____

Patient Signature:_____ Date:_____
(parent/legal guardian signature if patient is a minor)