COOS COUNTY FAMILY HEALTH SERVICES/COOS COUNTY FAMILY DENTAL

AUTHORIZATION TO REQUEST RECORDS/INFORMATION

Facility Name:_____

Address:_____

Phone Number:_____ Fax Number:_____

Is hereby granted permission to disclose copies of the undersigned's Medical/Dental Records to:

☐ Coos County Family Health Services, 133 Pleasant St., 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 St., Gorham, NH 03581, (603) 466-2741, fax: 466-2953

☐ Coos County Family Dental, 73 Main Street, Berlin, NH 03570, 603-752-2424, fax: 752-2436

Patient Name:_____ Maiden:_____

Address:_____

Date of Birth:_____ Phone Number:_____

Cell Phone Number:_____

Provider:_____

( ) Health/Dental Records/Information from _____ to _____.
(Date) (Date)

( ) No limitations placed on the 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 limitations placed on psychotherapy notes/communication. Initials_____

(** Must check and initial for Behavioral Health Records)

I understand:

- ❖ I may revoke this authorization at any time, except to the extent disclosures have already been made.
- ❖ My treatment cannot be conditioned on my signing this authorization, although CCFHS cannot be responsible for effective treatment without access to any medical records.
- ❖ CCFHS is a health care provider covered by the Federal Privacy Rule and it will not make further disclosures of this information except with my authorization.

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:_____