Monadnock
HEALTH PARTNERS
A Department of Monadnock Community Hospital

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: ____ Date of Birth: ____________________

Address:____ Phone: __________________________

I authorize (agency): ____ Phone:__________________________

Address: ____

to release my health information to the following person or organization:___________________________________

Address: ____

Phone: ____ Fax:______________________________________

___ My Complete Medical Record
___ The Portion(s) Circled: Laboratory Results Radiology Studies Test Results
___ Other, please specify: ____
For Only the Following Dates of Service: ________________________ to _________________________________
For the Following Purpose: ___Treatment ___ Patient Request ___ Transfer of Care ___ Other: ________________

DO NOT DISCLOSE MY MEDICAL RECORDS RELATED TO:
___ Drug and Alcohol Abuse Treatment __ Mental Health Treatment __ HIV (AIDS) Testing/Treatment __ Genetic Testing

By signing this release I am specifically authorizing Monadnock Health Partners to disclose information in its records, if any, related to drug and alcohol abuse treatment, mental health treatment, HIV (AIDS) testing/treatment, and genetic testing, unless I specifically refuse the release of any of this information as indicated above. Federal Law (42 CFR Part 2) prohibits those receiving information on drugs or alcohol treatment from re-disclosing it unless further disclosure is expressly permitted by written consent of the person to whom it pertains, or is otherwise permitted by 42CFR Part 2.

I Understand the Following:

- That I have the right to revoke this authorization at any time.
- If I revoke the authorization, I must do so in writing and present my written revocation to MHP.
- The revocation will not apply to information that has already been released in response to this authorization.
- The revocation will not apply to my insurance company when law provides my insurance with the right to contest a claim under my policy.
- Unless revoked, *this authorization will expire one (1) year from the date I sign it*.
- Authorizing the disclosure of health information is voluntary.
- I can refuse to sign this authorization.
- This form does not need to be signed in order to assure treatment.
- I may inspect or copy the information to be disclosed as provided in 45 RF 164.524.
- Any disclosure of information carries with it a potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- Questions about disclosure of my health information can be directed to the MHP Privacy Officer at (603) 924-2142.

____ ___________________________
Signature of Patient/Guardian Date

____ ___________________________
If signed by Guardian, Relationship to Patient Date

Expiration Date: ____