MASCOMA
COMMUNITY
HEALTH CENTER

Authorization for the Release of Information
HIPAA COMPLIANT RELEASE

Mascoma Community Health Center
PO Box 550/18 Roberts Road
Canaan, NH 03741
Phone: 603-523-4343
Fax: 866-277-5893

Patient's Name:_____DOB: _____

Release of Information ***TO / FROM*** *(circle one):* _____
_____
_____

TO / FROM *(circle one)****: Mascoma Community Health Center***

I hereby authorize and request the exchange of information between Mascoma Community Healthcare and the above-named individual/organization. The following information is requested to be shared:

○ All MEDICAL ○ All DENTAL

○ Only those items which are pertinent to this referral

○ Office Notes	○ Intake Assessment	○ Test Results
○ Psych/Social/Emotional Evaluation	○ Medications	○ Treatment Plan
○ Immunizations	○ Summaries	○ Discharge Summary
○ Counselor Reports	○ Teacher Reports	

Date range of records to release (check one): ○ Only documents from _____ to _____ ○ All dates

Reason for Request _____

Form of Disclosure (check all allowed): ○ Written ○ Verbal ○ Electronic

○ 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 (42CFR Par 2). Federal Law prohibits the disclosure of (1) psychotherapy notes, (2) information compiled in reasonable anticipation, or for the use in civil, criminal, or administration action or proceedings.

○ I understand I may revoke this authorization at any time by notifying **Mascoma Community Healthcare Inc.,** 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 or 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 a right to request and receive a **Notice of Privacy Practices** for Mascoma Community Healthcare, Inc.,

○ All releases expire one year from the date signed, unless otherwise indicated. Optional expiration date: _____

○ I hereby authorized 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 Representative) (Printed Name) (Relationship to Patient if Representative) (Date)