

**Goodwin Community Health Center**  
**311 Rte. 108 Somersworth, N.H. 03878**  
**Phone 603-749-2346 Fax 603-749-2748**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

I authorize Goodwin Community Health to request and receive disclose

**For Dates of Care From:** \_\_\_\_\_ **to** \_\_\_\_\_

**If Transferring, Reason:** \_\_\_\_\_

The personal health information of the above named individual as designated above, in communication with:

Agency/Individual \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**Initial the type and amount of information to be used or disclosed:**

- \_\_\_\_\_ Medical diagnostic, testing, and treatment information
- \_\_\_\_\_ Dental diagnostic, testing and treatment information and /or x-rays taken: \_\_\_\_\_
- \_\_\_\_\_ Immunization record
- \_\_\_\_\_ Current prenatal records, copies of all lab tests (including HIV results) and/or scans
- \_\_\_\_\_ Summary of labor and delivery notes; date of delivery: \_\_\_\_\_
- \_\_\_\_\_ Pregnancy Test Results
- \_\_\_\_\_ Sexually Transmitted Diseases
- \_\_\_\_\_ HIV/AIDS
- \_\_\_\_\_ Psychiatric/psychological evaluation(s), reports, assessments, summaries, psychotherapy notes or other documents with diagnosis, prognoses, recommendations, or testing records and behavioral observations.
- \_\_\_\_\_ Drug and Alcohol information including evaluation, diagnostic, treatment and progress notes.

**Reason for Disclosure:** \_\_\_\_\_

**Methods of Disclosure Authorized:** Faxed, written, phone conversation, in-person and/or secure e-mail

- I understand that I have the right to revoke this authorization in writing, at any time by presenting written notification to Goodwin Community Health. Revocation will be effective as of the date received.
- I understand that a revocation will not be effective to the extent that Goodwin Community Health has taken action in reliance on the authorization prior to the revocation date, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes.
- I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by federal privacy regulations.
- I understand that I have the right to: 1. Inspect or copy the protected health information to be used or disclosed as permitted under Federal law; 2. Refuse to sign this authorization.
- Unless otherwise revoked, I understand this authorization expires on \_\_\_\_\_.  
(If left blank, the authorization will expire upon conclusion of treatment).
- Unless otherwise noted only the past two years of electronic records within will be sent

**Signature of Patient and/or Legal Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*To receiving provider: This information has been disclosed to you from records whose confidentiality is protected by law. If the information is drug or alcohol abuse treatment information covered by 42 CFR Part 2, federal law prohibits you from making any further disclosures of this information without the specific written authorization of the individual to which it pertains., or as otherwise permitted by 42 CFR Part2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

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| <b>For office use only:</b> Witness: _____<br>Sent by: _____ | Date: _____<br>Date: _____ |
|--|----------------------------|