GREATER SEACOAST COMMUNITY HEALTH
Goodwin Community Health | Families First | Lilac City Pediatrics

Goodwin Community Health Center
311 Route 108, Somersworth, NH 03878
Ph: 603-749-2346 Fax: 603-749-2748

RELEASE OF MEDICAL INFORMATION

Patient Name: ______________________________ Date of Birth: ________________

Phone(s): ____

I authorize Goodwin Community Health to release or obtain personal health information of the above-named individual to the person/facility named below. ☐ **Release to** ☐ **Obtain from**

Name/Facility: ______________________________ Phone #: ________________

Address: ______________________________ Fax #: ________________

City, State, Zip: ______________________________ Email: ________________

For dates of care from: ______________________________ to: ________________

Purpose of release: ____

If leaving our practice, reason: ____

Please initial all types of information that you authorize us to release or obtain:

_____ Medical diagnostic, testing, and treatment information
_____ Dental diagnostic, testing and treatment information and /or x-rays taken: ________________
_____ Records of immunizations and physicals
_____ Current prenatal records, copies of all lab tests (including HIV results) and/or scans
_____ Summary of labor and delivery notes for the following date of delivery: ________________
_____ Information about Sexually Transmitted Diseases and/or 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.
_____ Other: ____

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

- I understand that I may revoke (withdraw) this authorization at any time by notifying Goodwin Community Health in writing. Revocation will be effective as of the date received.
- I understand that a revocation will not apply to: 1) any actions that Goodwin Community Health has already taken while relying on this authorization before I revoke it; or 2) 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 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 the recipient of some information disclosed under this authorization may re-disclose this information and that the information will no longer be protected by federal privacy regulations.
- I understand that I have the right to: 1) Inspect or copy the protected heath information to be used or disclosed as permitted under Federal law; 2) Refuse to sign this authorization.
- This authorization will remain in effect **for one year** and may be revoked at any time in writing.
- Unless otherwise noted, only the **past two years** of electronic records as stipulated above will be sent.

Signature of Patient and/or Legal Representative: ______________________ **Date:** __________

To receiving provider*: This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. 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.*

For office use only: Witness: ______________________________ Date: ____________

Sent by: ______________________________ Date: ____________

FOR PATIENTS WHO ARE LEAVING GOODWIN COMMUNITY HEALTH

I. TRANSFER OF CARE QUESTIONNAIRE

We care what you think! We would like your feedback on the care you received while a patient at Goodwin Community Health and the reason for transferring your care. Please take a few minutes to complete the following questionnaire. Any suggestions and comments are appreciated. Thank you for your time.

1) Why are you leaving Goodwin Community Health (GCH)? (Please check as many as apply.)

❑ Moving: Please list town and state: ____

❑ Change of Insurance*: Changed to: ____
If you checked this box, did you know GCH accepts private insurance? ❑ Yes ❑ No

❑ Other: Please explain below (use separate page if needed):

2) **Please answer these questions regarding office operations:**

a. Were you able to reach us when you needed assistance? ❑ Yes ❑ No
b. Were you able to make appointments when you needed them? ❑ Yes ❑ No
c. Was the length of time you waited at your appointment reasonable? ❑ Yes ❑ No
d. Was the staff responsive to your needs? ❑ Yes ❑ No

3) **Would you recommend GCH to others for their health care needs?** ❑ Yes ❑ No

4) **Do you have any ideas or suggestions to improve the services at GCH?**

Thank you for taking the time to complete the questionnaire. Your thoughts are valuable to us.
If we can be of further assistance, please do not hesitate to call us.

II. IMPORTANT INFORMATION FOR PATIENTS WHO ARE LEAVING GCH:

1. We will be cancelling any future appointments you may have booked, including dental appointments. (EXCEPTION: Patients under 19 years of age may continue to receive dental services without being a medical patient. If you would like your child to continue with dental, call 603-841-2025.)
2. We will be closing your case with our health center. If at any time you desire to return to the health center, we would be happy to welcome you back. Please call the office to re-establish care.
3. If you have family members who come to the health center and are also transferring their care, please tell us as soon as possible so we can cancel their future appointments as well. Please list their names here:

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4. If you need additional information, please call Medical Records at 603-994-6343.