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

Patient Name: _____ **DOB**: _____

I authorize Greater Seacoast 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: _____

Please send Electronic Dental Records to;
Dental@GoodwinCH.org

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 heath 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.*

For office use only: Witness: _____ Date: _____
Sent by: Date: