Ammonoosuc Community Health Services, Inc.

Littleton • Franconia • Warren • Whitefield • Woodsville

603.444.2464 • www.ammonoosuc.org

Authorization for Release of Previous Medical Records

Patient Name: ___________________ Birth Date: __________ Alias/Former Name:___________

☐ Receive Previous Medical Records from (Provider/Organization): ____

Address ____ Phone: ________________________

☐ Release Medical Records to (Provider/Organization): ____

Address ____ Phone: ________________________

I hereby authorize and request the exchange of information (verbally or in writing) between Ammonoosuc Community Health Services and the above-mentioned individual/organization. The following information is requested to be shared:

☐ Office Notes	☐ Imaging Reports	☐ Hospital Correspondence
☐ Medication List	☐ Pathology Reports	☐ Social Work Reports
☐ Immunizations	☐ Prescription Information	☐ Internal Correspondence
☐ Lab Results	☐ Consultation Reports	☐ External Correspondence
☐ Chart Summary	☐ Diagnostic Reports	☐ Previous Medical Records

☐ Other: ____

I hereby authorize disclosure of the following (please initial if applicable):

Sexually transmitted disease	Initial______	Drug and/or alcohol treatment	Initial______	Behavioral Health	Initial______
HIV (AIDS) testing/treatment	Initial______	Hospitalizations	Initial______	Genetic testing	Initial______
Intake Assessment	Initial______	Psychiatric	Initial______		

The purpose of this release is to expedite: ☐ Transfer of Care ☐ Sharing of Care

Dates: From: _______________ **To:** _______________

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

I understand I may revoke this authorization at any time by notifying ACHS 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 of 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 the right to request and receive a Notice of Privacy Practices from ACHS.
All releases expire one year from the date signed unless otherwise indicated.

____ ___________________________

Signature of patient or patient's representative **Relationship**

Witness ____ **Date:** ______________________

Prohibition of Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.