COOS COUNTY FAMILY HEALTH SERVICES/COOS COUNTY FAMILY DENTAL

☐ **Coos County Family Health Services, 133 Pleasant Street, Berlin, NH 03570, (603) 752-2040, fax: 752-7797**

☐ **Coos County Family Health Services, 59 Page Hill Road, Berlin, NH 03570, (603) 752-2900, fax: 752-3727**

☐ **Coos County Family Health Services, 2 Broadway Street, Gorham, NH 03581, (603) 466-2741, fax: 466-2953**

☐ **Coos County Family Dental, 73 Main Street, Berlin, NH, 03570, (603) 752-2424, fax: 752-2436**

AUTHORIZATION FOR RELEASE OF RECORDS/INFORMATION

Patient Name:____________________________ Date of Birth:______________________

Address:_________________________________ Phone Number:_____________________
(Street, City, and State) Cell Phone Number:_________________

( ) Health/Dental Records/Information from _____________ to _________________.
(Date) (Date)

☐ All (initial below)	☐ Immunization Records	☐ Dental
☐ Emergency Department Report	☐ Radiology Report	☐ Other:_____________
☐ Practitioner Office Note	☐ Chart Summary (initial below)	
☐ Physical Exam Letter/Form	☐ Laboratory Report	

( ) No limitations placed on history of illness with diagnostic and therapeutic information including HIV testing or disease, substance abuse, psychiatric care or mental health information and genetic testing.

(Patient must initial if this item is checked) Initials_________

( ) No limitation placed on psychotherapy notes/communication. Initials:_______

I understand:

- I may revoke this authorization at any time, except to the extent CCFHS has already authorized disclosures.
- CCFHS may not condition treatment on my willingness to sign this authorization.
- If the entity to which I have authorized disclosure is not a health care provider or health plan subject to the Federal Privacy Rule, the information could be disclosed to other parties without being protected by the Privacy Rule.

The undersigned hereby authorizes CCFHS to disclose my health care/dental record/information to:

Facility Name:____

Address:____

Phone Number:______________________ Fax Number:______________________________

Purpose of Disclosure:____

This authorization shall expire 1 year from the date of signing. A photocopy of this authorization shall be accepted with the same authority as the original.

Print Name:________________________

Patient Signature:___________________________ Date:________________
(parent/legal guardian signature if patient is a minor)