

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION FROM NASSON HEALTH CARE

Client Name: _____ **Date of Birth:** _____

I authorize/request Nasson Health Care to release information to:

Organization Name	Address	Telephone Number	Fax Number
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Nasson Health Care is authorized to disclose and discuss the following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> EKG | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Last Mammogram Report |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Operative Notes | <input type="checkbox"/> Medication Record | <input type="checkbox"/> Last Dental X-Rays –within 1 year |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Last Pap Report | <input type="checkbox"/> Office Notes – within 3 year |
| <input type="checkbox"/> Other: _____ | | | |

I DO _____ / DO NOT _____ authorize the release of any information, which refers to the diagnosis or treatment of **ALCOHOL OR DRUG ABUSE** under this authorization.

I DO _____ / DO NOT _____ authorize the release of any information, which refers to the diagnosis of treatment of **MENTAL HEALTH** under this authorization.

I DO _____ / DO NOT _____ authorize the release of any information, which refers to the testing, diagnosis or treatment of **HIV/AIDS**.

Purpose of the above release (*Place a check mark by each appropriate option*)

The information and material above may only be used for the following purpose(s):

- | | | |
|---|---|--|
| <input type="checkbox"/> Verification of Services | <input type="checkbox"/> Ongoing Service Coordination | <input type="checkbox"/> Treatment/Service Planning |
| <input type="checkbox"/> Transfer my healthcare | <input type="checkbox"/> Legal Matter | <input type="checkbox"/> Other (<i>specify</i>): _____ |

My signature below indicates that I have read this release form and have had all of my questions answered, if any. I understand:

- I understand that this form authorizes the release of information as indicated on this form.
- I have the right to revoke this authorization verbally by speaking with designated NHC staff or by submitting a Revocation in writing at any time. Revocation will not cover information/material released prior to that date, but will prevent further release of information. I understand that revocation may be the basis for denial of health benefits or insurance coverage or benefits.
- I authorize the party(s) I have authorized to make subsequent disclosures to the same recipient pursuant to this authorization.
- I understand that information released by Nasson Health Care might be further released by the receiving party noted above, and that if this occurs; Nasson Health Care cannot guarantee the protection of this information once disclosed.
- I understand that the recipient of such information may not further release this information without my specific consent or unless permitted by law. I understand that health care information is confidential and will not be released without my authorization unless permitted or mandated by law. I understand that I have the right to refuse authorization to disclose all or some health care information, but refusal may result in improper diagnosis or treatment, or denial of insurance coverage.
- I understand that my records pertaining to alcohol and substance use are protected under Federal Regulation, 42 CFR Part 2, which prohibits these records from being disclosed or re-disclosed without written consent, unless otherwise provided for in the regulations. **Re-disclosure** of my records by those reviewing the above authorized information may not be accomplished without my written consent.
- I understand that I have the right to review indicated material before it is released.

This authorization expires: **6 months from today, or** **On ___/___/___ Specify date**

Client Signature _____ **Date** _____

Representative* _____ **Date** _____

***Relationship to client** ___ Parent ___ Legal Guardian ___ Other Legal Representative (*specify*): _____