Cottage Hospital
90 Swiftwater Road
Woodsville, NH 03785
(603) 747-9000

Authorization for Disclosure of Medical Information

Patient's Full Name_____ Date of Birth_____

This will authorize **Cottage Hospital** to use or disclose my protected health information to [other entity] _____as described below for the following purpose:
_____
_____

Copies will be confined to the following records:

_____ Complete copy of medical record
_____ Other (describe)_____
_____ Psychotherapy Notes Only (If applicable, no other information may be included in authorization)

The information authorized for disclosure may relate to: [check all that apply]:

_____Mental illness (excluding psychotherapy notes) _____ HIV related illness _____AIDS
_____Drug or alcohol treatment (further re-disclosure prohibited or governed by 42 CFR Part 2)

☐ I understand that I may inspect or copy the protected health information described by this authorization.

☐ I understand that this authorization may be revoked in writing and delivered to the Privacy Officer of Cottage Hospital at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.

☐ I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

☐ I understand that Cottage Hospital shall not condition treatment, payment, or enrollment in a health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION FORM.

☐ I understand that Cottage Hospital shall have the opportunity to obtain direct or indirect remuneration in the form of [describe]: _____ from [third party]: _____ as a result of this authorization.

_____ _____
Date Signature of individual or representative

_____
[Authority of relationship of representative]

_____
Witness

* * * *

EXPIRATION DATE: This authorization will expire on [date or event]_____
(If no date or event is stated, expiration is six months from the date it was signed.)

COPY PROVIDED: Cottage Hospital shall provide a copy of this authorization , when signed, to the patient.

MEDICAL RECORD: Cottage Hospital will file a copy of this signed authorization in the patient's medical record.