CELL & HOME PHONE _____

EMAIL _____

Authorization for Use or Disclosure of Health Information

I, _____, _____, hereby authorize
(First and Last Name of Patient) **(Date of Birth)**

HealthFirst Family Care Center to use or disclose my health information as indicated:

☑ **Provide information to:** ❒ **Obtain Information from:** ❒ **Exchange information with:**

Name/Agency: Mascoma Community Healthcare Inc. **Address:** PO Box 550 Canaan, NH 03741
Phone/Fax #s: 603-780-4242 director@mascomahealth.org 603-523-4343 as of 11/1/25
Date to be obtained/released records: **From:** ~~1/1/22~~ and **To:** ~~10/31/25~~

Information being requested for release: (please check the appropriate items)

☑ Medical, diagnostic, testing, and treatment information
☑ Medication list (including prior authorization documents)
☑ Summary of labor delivery notes
☑ Current Prenatal records, all lab tests and imaging.
Date of delivery: _____
☑ Pregnancy test results
☑ Immunization records, and/or ❒ Growth chart ❒ Other (Specify): _____

***SENSITIVE INFORMATION. I approve the release and disclosure of the following types of sensitive information (check all boxes that apply).**

☑ Psychotherapy/ Psychiatric/psychological evaluation(s), reports, assessments, summaries, documents with diagnosis, prognoses, recommendations, or testing records and behavioral observations
☑ Sexually transmitted disease (including HIV results and treatment)
☑ Drug and Alcohol information including evaluation, diagnostic, treatment and progress notes

Reason for Disclosure: (Please check the appropriate item)

☑ Transferring care to another provider/facility ❒ School ❒ Legal ❒ Moving ❒ For personal records
☐ Other (Specify): _____

Methods of Disclosure Authorized: Fax, written, phone conversation, in-person and/or secure e-mail

- I understand that this authorization will expire one year from the signed date. A photocopy of this form will be considered as valid as the original.
- I may inspect this health information before it is disclosed by making an appointment to review my record.
- I understand my refusal to sign this authorization will not affect my right to obtain present or future treatment except where the disclosure of the information is necessary for the treatment.
- I may withdraw my authorization by completing another form. This withdrawal will be effective on the date of signature except to the extent action has already been taken upon it.

_____ _____
Signature of Patient/Legal Guardian/Parent **Date**
If you are a parent or legal guardian please print your full name here:_____

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 treatment information covered by 42 CFR part 2, federal low prohibits you from making any further disclosures of this information with the specific written authorization of the individual to which it pertains, or a otherwise permitted by 42 CFR part 2. 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.

Office use only: Processed by:_____ **Date:**_____