HEARTHSIDE
Family Health
Direct Primary Care Health

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name: _____DOB: _____ Date_____

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize my health care provider:

- ❑ _____ (*which practice is chart COMING from*)

- ❑ Hearthside Family Health,

-to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below. I expressly understand that this includes covered entities under HIPPA and may include information relating to sexually transmitted diseases, AIDS, HIV and alcohol and substance abuse. I authorize the release of this type of information unless expressly written below.

Recipient: I authorize my health care information to be released to the following recipient(s): (*where chart is GOING to*)

X Hearthside Family Health, 109c Grove St, Peterborough NH, 03458
Phone: 603 312 1600, Fax: **603 371 2629**

Purpose: I authorize the release of my health information for the following specific purpose:

at the request of the patient

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me. Including STI and substance abuse records.
- ❑ Only the following records or types of health information:
  _____.

Term: I understand that this Authorization will remain in effect for *ONE YEAR* unless specified below

- ❑ From the date of this Authorization until the _____ day of _____, 20___.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs:_____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this https://www.app.elationemr.com/book/65260601475076Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to Hearthside Family Health, LLC. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

_____ _____
Signature Date

If Individual is unable to sign this Authorization, please complete the information below:

_____
Name of Guardian/Representative Legal Relationship