

**COOS COUNTY FAMILY HEALTH SERVICES, INC.**

- 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

**AUTHORIZATION FOR RELEASE OF RECORDS/INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
(Street, City and State) Cell Phone Number: \_\_\_\_\_

( X ) Health Records/Information from \_\_\_\_\_ to \_\_\_\_\_  
(Date) (Date)

- All (initial below)
- Physical exam letter/form
- Chart Summary (initial below)
- Emergency Department report
- Immunization records
- Laboratory report
- Practitioner office note
- Radiology report
- Other: \_\_\_\_\_

( ) 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: \_\_\_\_\_

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 record/information to:

Facility Name: The Family Resource Center- Project Youth Afterschool Programs

Address: 123 Main Street

Phone Number: 466-5190 Fax Number: 466-9022

Purpose of disclosure: Enrollment in Afterschool Program- required by NH Childcare Licensing

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: \_\_\_\_\_  
( parent/legal guardian signature if patient is a minor)

Date: \_\_\_\_\_