COMMUNITY ACTION PROGRAM
BELKNAP-MERRIMACK COUNTIES, INC.
EMPOWERING COMMUNITIES SINCE 1965

FAMILY PLANNING PROGRAM
PERMISSION TO SHARE PATIENT HEALTH INFORMATION

PATIENT INFORMATION

Patient Name: Date of Birth: Phone Number: ( )

Address: City: State: Zip Code:

FACILITY

Laconia Family Planning | Community Action Program Belknap-Merrimack Counties *Phone*: 603-524-5453
121 Belmont Road, Laconia, NH 03246 *Email*: FamilyPlanning@capbm.org *Fax*: 603-528-2795

RECIPIENT

I authorize CAPBM Family Planning Program to share my health information with:

Name of Person/Entity: _____

Title (Physician, Attorney, Etc.): _____ Phone Number: ( )

Street Address: _____

City: _____ State: Zip:

Purpose of Disclosure: ☐ Medical Care ☐ Insurance ☐ Legal ☐ Transferring to New Provider
☐ Other (specify): _____

HEALTH INFORMATION TO BE SHARED

***Copies* of my health information within the following dates:** _____ **to** _____

☐ **Abstract OR check only those documents needed:**

☐ Immunizations ☐ Outpatient Visit (Office) Notes ☐ Imaging Reports
☐ Laboratory/Pathology Reports ☐ Other _____

Delivery Preference: ☐ Pickup ☐ Mail ☐ Fax (for Medical Care purposes) - Fax Number: ( )_____

SENSITIVE HEALTH INFORMATION

By initializing below, I authorize CAPBM Family Planning Program to use or share the following Identifiable Health Information:

_____Mental Health Treatment Records (NOT psychotherapy notes) _____Genetic Testing
_____Sexually Transmitted Infections (STI) Treatment Records _____HIV/AIDS Test Results (pursuant to RSA 141-F:8)

Please note that substance use disorder records and psychotherapy notes are specially protected by state and federal laws (42 CFR Part 2, 45 CFR Parts 160 & 164) and require separate signature authorizations. I authorize disclosure of:

_____Alcohol/Substance Abuse Treatment Records _____Psychotherapy Notes

Federal rules prohibit any further re-disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Specific information that may be used or disclosed: _____

_____

DURATION & REVOCATION

This authorization will remain in effect for one year from the date of the signature below, unless you specify a different date here:_____(expiration date). You or your Personal Representative may revoke this authorization at any time by providing written notice to CAPBM Family Planning Program's Medical Records Department, as specified in our Notice of Privacy Practices; however, your revocation will not apply to any previously released information.

ADDITIONAL INFORMATION

- I understand that the information I authorize the above person(s) or entities to receive may be redisclosed by such parties and is no longer protected by federal regulation. *See* 45 CFR § 164.508(c)(2)(iii).
- I understand that I may inspect or request copies of any information disclosed by this authorization. I understand that I have a right to receive a copy of this authorization. I understand that I may revoke this authorization at any time by notifying, in writing, CAPBM Family Planning Program's Medical Records Department, knowing that previously disclosed information would not be subject to my revoke request.
- I understand that this authorization is voluntary, and I may refuse to sign this authorization. My refusal to sign this authorization will not affect my ability to obtain treatment, payment or my eligibility for benefits.

SIGNATURES

_____ _____

Patient or Legal Representative **Date** **Witness** **Date**

_____

Printed Name of Patient or Legal Representative