Visiting Nurse Home Care & Hospice of Carroll County

PO Box 432 • North Conway • New Hampshire 03860

Sandra Ruka, MS RN
Executive Director

www.vnhch.org

603-356-7006
800-499-4171
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Authorization for Release of Medical Information

Patient's Name:	Date of Birth:
SSN:	Patient's Phone #:
Mailing Address:	
City/State/Zip:	

☐ I authorize Visiting Nurse Home Care & Hospice of Carroll County to **release information to**:	☐ I authorize Visiting Nurse Home Care & Hospice of Carroll County to **obtain information from**:
Name of Provider or Facility	Name of Provider or Facility
Address	Address
City, State, Zip	City, State, Zip
Phone #/Fax # (include area code)	Phone #/Fax # (include area code)

Purpose of this Request: (check one) ☐ Healthcare ☐ Transfer of Care ☐ Insurance Coverage ☐ Personal ☐ Other

Type of Records Requested: (check one)

☐ Immunization history

☐ All medical records related to a specific illness or injury:

_____ _____
Specific illness/injury Date(s) of treatment

☐ Specific Information: (select one or more, as applicable)

☐ Nursing Notes ☐ Physical Therapy Notes ☐ Occupational Therapy Notes
☐ Speech Therapy Notes ☐ Laboratory Test Results ☐ Social Worker Notes
☐ Other: (please specify) _____

☐ Complete Medical Record

Authorization Valid for: (check one)

☐ This request only

☐ One year from the date of this authorization **or** _____(insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.

☐ This request **and** for medical records of any ***future*** treatment of the type described above until: _____ (insert date).

I understand that:

- My right to healthcare is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

Signature of Patient or Representative:_____Date:_____

Relationship to Patient (if requester is not the patient):_____