Merrimack County Nursing Home
Authorization To Obtain, Use or Disclosure of Protected Health Information

Name of Resident (type or print)_____ Date of Birth:_____

I hereby authorize the Merrimack County Nursing Home to Obtain, Use and Disclose my health information as indicated below. I understand that this release is voluntary and that I may revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. I also understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be disclosed to others and no longer protected by current state and federal privacy regulations.

I hereby authorize the obtaining/release or use of the information checked and/or listed below for the time period beginning on _____and ending on _____:
or upon the completion of the use of the information for the purpose it was intended, whichever is earlier

_____
Facility/Agency/Physician Address

_____
Facility/Agency/Physician Address

_____
Facility/Agency/Physician Address

_____
Facility/Agency/Physician Address

_____
Facility/Agency/Physician Address

[ ] Complete health care record(s)
[ ] History & Physical Examination
[ ] Minimum Data Set
[ ] Laboratory Reports
[ ] Medical / Treatment Records
[ ] Pathology Reports
[ ] X-Ray Reports
[ ] Transcribed Reports
[ ] Nurses' Notes

[ ] Discharge Summary
[ ] Progress Notes
[ ] Care Plans
[ ] Dental Records
[ ] Photographs, or other images
[ ] Billing Statements
[ ] Emergency Care Records
[ ] Consults
[ ] Psychological

[ ] Patient Care Referral forms 1&2
[ ] Comprehensive Assessment Form
[ ] Social Info
[ ] Other
[ ] Other
[ ] Other

The information checked and/or listed above is to be released to: _____
for the purpose(s) of _____
_____

I understand that I may revoke this request at anytime by providing the facility with my written notice of such revocation.

I understand that I may inspect and copy any information used or disclosed under this authorization. I understand that a fee may be charged for such copying services

Date:_____ Signature of Resident:_____
Printed Name of Resident:_____

Date:_____ Signature of Representative:_____
Printed Name of Representative:_____
Relationship to Resident:_____

Date:_____ Signature of Witness:_____
Printed Name of Witness:_____

A copy of this record must be provided to the person making the request and a copy must be filed in the medical record.