

ANDROSCOGGIN VALLEY HOSPITAL / AVH SURGICAL ASSOCIATES
AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

You may tear off this page and retain it for your records.

By signing this authorization, you are permitting the use and/or disclosure of your health information for the limited purpose(s), and in the limited manner, described in this form. Except as authorized by this form, we are required by federal law to maintain the privacy of your health information as described in our Notice of Privacy Practices.

Refusals of Service

If the only reason you have asked us to provide a health care service is so that we can create information to be disclosed to a third party, we may refuse to provide the service if you refuse to sign this authorization. For example, if you have requested a drug test solely for the purpose of having the results disclosed to your employer, we may refuse to perform the drug test if you refuse to sign this authorization permitting us to disclose the results to your employer.

Otherwise, your ability to receive treatment, payment, enrollment in a plan, or eligibility for a benefit does not depend on your signing this form. **You may refuse to sign this form.**

(Note to Workforce Members Presenting this Form: If the treatment of the patient, payment for the patient's care, or enrollment of the patient in a health plan is conditioned on the patient signing this form, no use or disclosure other than that upon which treatment, payment, or enrollment has been conditioned can be authorized on this form. A separate authorization would be needed for any other use or disclosure.)

Consequences of Signing this Form

Signing this authorization may cause the health information used or disclosed pursuant to this authorization to no longer receive the protections of federal privacy laws. Any person or organization to whom your health information is disclosed pursuant to this authorization might be able to legally re-disclose that information to others.

Revocation

You may revoke this authorization at any time, in writing, except to the extent that we have already relied upon it in making a use or disclosure. Your written revocation will become effective when we have knowledge of it. If you are providing this authorization to obtain insurance coverage, you may not have the right to revoke the authorization to the extent that it pertains to the insurer's right under law to contest a claim under your insurance policy. If you wish to revoke this authorization, please send your written request to: Jean Wolf, Privacy Officer, Androscoggin Valley Hospital, 59 Page Hill Road, Berlin, NH, 03570.

Expiration

Once this authorization has expired, we will no longer use or disclose your health information for the purpose listed in this authorization unless you sign a new authorization form.

ANDROSCOGGIN VALLEY HOSPITAL / AVH SURGICAL ASSOCIATES
PATIENT AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

I hereby authorize employees, Medical Staff members, or other agents of Androscoggin Valley Hospital and/or AVH Surgical Associates to use or disclose the following health information about me:

- Billing claim Consultation report Laboratory report Radiology report
- Billing statement Discharge summary Operative report Remittance advice
- Cardiology report ED report Practitioner office note X-ray film/CD

Other: _____

Other: _____

Specify date(s) desired: _____

Special Confidentiality Issues: Not Applicable

I do or do not authorize the use/disclosure of health information related to HIV/AIDS.

I do or do not authorize the use/disclosure of health information related to genetic testing.

for the following purposes:

- at the request of the undersigned individual second opinion disability benefits
- further medical follow-up treatment insurance company attorney
- other (describe): _____

The health information described above may be used by or released to:

- Me
- Name: _____
- Address: _____

This authorization expires:

- Six months from today. On ___/___/___ (enter date)
- When the following event occurs: _____

Witness Patient's signature

Date Time Cross one out am/pm

The above individual is unable to consent because (check one):

- Minor Incapacitated Deceased (Proof of administrator of estate required)
- Other (explain): _____

I therefore consent on behalf of the individual named above.

Signature Relationship to Patient

Date Time Cross one out am/pm