



SPAULDING YOUTH CENTER

Medical

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize Spaulding Youth Center
130 Shedd Road
Northfield, NH 03276

To mutually disclose my child and family protected health information as described below:

(name and address of recipient) Franklin Regional Hospital
Franklin, NH

for the following purposes: (describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)
Child and family Treatment

I understand that:

- 1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
- 2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
- 3) I may revoke this authorization at any time by notifying Spaulding Youth Center in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
- 4) if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, the released information may no longer be protected by federal privacy regulations.

Type of Information to Be Disclosed

- | | | |
|--|---|--|
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Most Recent 5 Year History | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Office Chart Notes | <input type="checkbox"/> All Hospital Records | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Transcribed Hospital Reports | |
| <input type="checkbox"/> Dental Records | <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Emergency and Urgent Care Records | |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Medical Records for Continuity of Care | |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Diagnostic Imaging Reports | |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Emergency Room Reports | |

In addition, I authorize that this will include health information relating to (check if applicable):

- ☐ HIV/AIDS infection ☐ Drug/Alcohol abuse ☐ Genetic Testing

Expiration:

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This authorization will expire 180 days from the date of signing or (insert date) _____.
(Not to exceed 1 year)

Client Name: _____

Client ID #: _____ DOB: _____

Signature of Client or Legal Representative

Date

Printed Name of Client's Representative (if applicable)

Relationship to Client (if applicable)

- ☐ Parent or guardian of unemancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

Signature of Witness

Date