

NEW HAMPSHIRE HOSPITAL
36 Clinton Street Concord, NH 03301
Telephone 603-271-5522
Fax: 603-271-5784

Patient's Name _____

Date of Birth _____

I (Print Name of Patient or Legal Representative) _____

hereby authorize NH Hospital to disclose education records as described below for the purposes of:

Dates From: _____ to: _____

To: Name _____

Street/City/State _____

Phone Number: _____ Fax Number _____

Information To Be Disclosed to the Above Person or Organization:

- Transcripts (prior to July 1, 2010) Education Progress Notes Verbal Exchange of Information
 Information from other educational facilities Correspondence Re Education Individual Educational Plans (IEP)
 Other (list): _____

By signing this Authorization for Disclosure of Education Information, I understand that:

1. A Photocopy or fax of this authorization shall be as valid as the original.
2. This Authorization for Disclosure of Education Information is not a required condition for treatment.
3. If the person(s) or organizations(s) authorized to receive the information is not a health plan or health care provider, the disclosed information may be re-disclosed and would no longer be protected by federal privacy regulations.
5. The Authorization for Disclosure of Education Information shall be effective for a period of one year
6. This authorization may be revoked at any time. The request to revoke an authorization to disclose information must be in writing and delivered to the Health Information Department of NH Hospital. Upon receipt of written revocation, NH Hospital must immediately cease disclosure of education records, except to the extent that action has been taken or information disclosed prior to the date or revocation
7. Information disclosed may include psychiatric, substance abuse, HIV infection, AIDS, or tests for HIV
8. NH State law requires that education records created during a stay at the Anna Philbrook Center are kept for a period of 6 years. Transcripts or maintained permanently as required by State law.

Signature of Patient/Legally Authorized Representative

Relationship if not the patient

Date

NEW HAMPSHIRE HOSPITAL
Authorization for Disclosure of
Education Information

PATIENT IDENTIFICATION