WHITE MOUNTAIN COMMUNITY HEALTH CENTER
Whole Person. Whole Family. Whole Valley.

← Fill out these forms online
whitemountainhealth.org/become-a-patient

Welcome to White Mountain Community Health Center

White Mountain Community Health Center looks forward to working with you and your family. Your care and wellness are our primary goals.

We are pleased that you have selected us as your healthcare home. Enclosed are forms you must complete before you schedule your appointment to establish care. Please fill out these forms completely in blue or black ink.

In order to better serve you, we ask that you bring a list of all your medications, insurance cards, completed forms, and other documents you feel are important to your visit. Please plan to arrive 15 minutes prior to your appointment.

If you are unable to easily read or understand the required forms, please bring them with you to your appointment and one of our staff will assist you.

Our Promise to You

- You are the most important member of your healthcare team.
- We are dedicated to providing coordinated, evidence-based care across all of your healthcare systems.
- Coordinating your care works best when patients provide their team with all of their healthcare information.
- We want you to think of White Mountain Community Health Center as your healthcare HOME - where all your care comes together.

If you see other healthcare providers outside of the health center, it is important to share this information with us, as it gives us important information about your overall health and wellness to help us serve you better.

Getting Started as a New Patient at White Mountain Community Health Center

- Please review this important information, complete all forms, including the record release, and return it to our office.
- Once your paperwork arrives, we will contact your previous provider(s) for your records. This process can take up to 30 days.
- If you have an urgent or immediate health concern, please let us know and we will do our best to get you in as soon as possible. Generally, we are able to accommodate urgent visits within a day or so. It is still important for you to also schedule your "establish care" visit with your selected provider.
- If you have any questions or need assistance, please contact the front desk at (603) 447-8900.

Selecting Your Provider/Care Team Lead

It is important for you to feel comfortable with your provider and be able to play an active role in your healthcare planning and goals. Visit our website at www.whitemountainhealth.org and "meet" our providers. Each provider has a profile and bio to help you find the best match for you. If you need help making your choice, we would be happy to assist you.

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How Your White Mountain Community Health Center Care Team Works for You

- Our providers work in teams to help meet your needs. This ensures you will have access to a member of your provider's care team, even if he/she is not available.
- You will have access to medical, behavioral health, and dental services to meet all your primary care needs.
- Your Care Team will work with you to connect with any specialists or other providers you see outside of our agency to help in coordinating your care. When you see other healthcare providers outside of the health center, it is important for you to ask them to share your health information from the visit with your primary care provider here.

Important Information for Your First Visit

Bring with you all of the following:

- ☐ Insurance card(s)
- ☐ List of all your medications and supplements or the bottles
- ☐ Complete sliding fee discount program application, if needed and not already submitted
- ☐ Any other documents you feel are important to your visit.

Plan to arrive 15 minutes prior to appointment to complete the check-in process.

Location and Hours

Monday - Friday 8:30 AM - 4:00 PM
298 White Mountain Highway
Conway, NH 03818
Phone: (603) 447-8900
Fax: (603) 447-4846

Appointments

- Simply call our office to schedule your appointment. Same day appointments are often available for acute or urgent health concerns.
- Please arrive 15 minutes prior to your appointment to complete the check-in process, which may include health screening paperwork.
- Bring a list of your current medications and information about any recent healthcare services you have received outside of White Mountain Community Health Center.
- Please notify our office immediately if you need to change or cancel your appointment.
- Your health and safety are our top priority. There could be times when you may be advised to go to the nearest Emergency Department instead of coming to the office.

After-Hours Access

Our patients can access advice by phone for urgent health concerns anytime we aren't open via our nurse triage on-call service. You can access this by calling us at (603) 447-8900.

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If you need to reschedule or cancel an appointment

We know life happens! If you are unable to make a scheduled appointment, please be sure to let us know as soon as possible.

- To avoid charges for a late cancelled or missed appointment, please be sure to call and cancel your appointment within 24 hours.
- If you have three or more late cancelled or missed appointments in one year, we may restrict you from scheduling appointments ahead of time.

Prescribing Medications at Your First Visit

In order to ensure you have the correct medications for your conditions and health concerns, before any prescription is filled for a new patient:

- Your medical records must be received from your previously prescribing provider(s) – this sometimes takes up to 60 days from the time of our request and your first appointment. **Please plan accordingly with your previous provider to ensure you do not run out of medication before your appointment**.
- If you have an active prescription and will be in need of refills, it is imperative you indicate this to our staff when you are contacted to schedule an "Establish Care" visit.
- You MUST be seen for an "Establish Care" visit, at which, the following will occur:
  - Review of existing health conditions, including evaluation and treatment history,
  - Review of your current medications,
  - Physical exam as needed to determine the necessity for the requested medications, and
  - If controlled substances are considered, a review of our policy for prescribing controlled medications and completion of a controlled substance contract is required.
- Your new provider is not obliged to prescribe any previously prescribed medications you may be taking. There are often many options for treatment of chronic conditions and these will be reviewed with you at the visit. Any medications prescribed must be deemed appropriate by your provider for your current condition(s) and based on your medical history.

Services to Ensure Your Visit is a Great Experience

Interpretation and Language Services: We will provide an interpreter for our patients as needed at no cost, including ASL. Please let our office know ahead of time so we are able to plan accordingly.

Español Atención: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.

Assistance Completing Forms: If you would like assistance in completing your forms, we are happy to help. Simply call us to schedule a time to meet with a member of our team.

Assistance in Managing the Cost: We offer health insurance enrollment assistance, a sliding fee scale, and other assistance. Please call our office at (603) 447-8900 to learn more.

Assistance with Transportation to Your Visit: If you need assistance with transportation, let us know. Sometimes we are able to help coordinate a ride to and from your appointment or a referral.

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Patient Portal

Our patient portal gives you 24-hour access to your personal health information and medical records. You can also use it to send secure messages to our staff, request a change to an existing appointment, request a prescription refill, and more. If you provide your email address, we will send you a sign-up link. If you don't get this email or need to reset your password, contact us at (603) 447-8900.

We Welcome All People

White Mountain Community Health Center complies with applicable federal civil rights laws and does not discriminate on the basis of color, race, national origin, age, disability, sexual orientation, or gender identity.

Payment Options for Your Care

We accept most insurance carriers serving this region. We know that figuring out your insurance coverage is sometimes confusing. If you have any questions or need help navigating your coverage, call our office at (603) 447-8900.

General Payment Information

- Please let us know if you have any changes to your health insurance so we are able to submit your claim to the appropriate carrier.
- You will be responsible for all outstanding balances not covered by insurance.
- Co-pays are due on the day of your visit.
- Claims will be processed to insurance companies we do not contract with, but unfortunately, we cannot guarantee coverage or payment.
- Our office accepts personal checks, cash, and most major credit cards.

Financial Assistance is Available

If you think you might have trouble paying your medical bills, we offer a sliding fee scale to those who qualify. To learn more or begin the eligibility process, please call our office at (603) 447-8900 and they will gladly assist.

Contact Your Insurer Before Your Visit

- If you have a behavioral health appointment, it is important to contact your health insurance company in advance to receive their approval/authorization to avoid charges that your insurance may not cover. Be sure to ask about copay and deductible amounts, they may be different from your medical visit coverage.
- Insurance coverage for other services may vary as well. Please feel free to contact our billing office if you need help figuring out what your charges will be for any service you are considering.

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Summary of Payment and Billing Policies

General

- Please be sure to bring your Insurance card(s) with you to each visit.
- White Mountain Community Health Center will request payment of all co-payments and charges not covered by a third party (insurance) at the time of your visit.
- Copayments and sliding fee scale payments are due in-full, at the time of service. Outstanding balances are due within 30 days of your visit.
- No show/late cancels may be charged $50

Sliding Fee Discount Program

- Sliding fee discounts apply only to services provided by the health center. It is your responsibility to renew your application before it expires.
- The discount is ***not insurance*** and will not pay for services provided by other doctors, labs or hospitals. You will need to make arrangements with these organizations directly.
- Nordx Laboratory and Memorial Hospital are willing to honor the White Mountain Community Health Center determination of discount for their own discount programs when we refer you.

Unpaid Balances

- You will receive a monthly billing statement from us until your balance is paid in full.
- We reserve the right to charge interest and collection fees.
- Payment plans are available for those unable to make payment in full. If you would like to set up a payment plan, please speak with the cashier or contact our billing department at (603) 447-8900.
- We understand that many patients are in situations that keep them from being able to pay their full bill. Please be in touch if you need extra assistance and explain your situation. We will do all we can to help as long as you stay in contact with us and stay current with the payment plan you've set up. In the event that your account balance remains outstanding for more than 120 days and you have not met these criteria, we may choose to place your account with a collections agent.
- If you don't make any payments for more than 120 days and you haven't been in contact with us about it, we may choose to place your account with a collections agent and suspend your ability to access care at the health center. Please call our billing department us if this happens to you. We can help you get back on track.

WHITE MOUNTAIN COMMUNITY HEALTH CENTER

NOTICE OF PRIVACY PRACTICES
REVISED 12/26/2018

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you come to **White Mountain Community Health Center**, we keep a record of your care and treatment. We take the protection of your personal information seriously. We are required to provide you with this **Notice of Privacy Practices** to tell you about our legal duties and ways we may use and share your information, and to inform you about your rights regarding your health information. We give a small number of examples to describe what the categories mean, but not every use or disclosure can be listed on this Notice.

You have a right to a paper copy of this Notice of Privacy Practices.

We will ask you to sign a written acknowledgment of receipt of our Notice. We reserve the right to change the terms of this Notice and post the current Notice in our office. You may obtain an updated Notice from our practice at any time.

How We May Use and Disclose Protected Health Information:

For Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and related services in our office or with a third party. For example, we may share your protected health information with a pharmacy for filling prescriptions, a laboratory or imaging center if you need diagnostic services, with a specialist to whom we refer you, or with a home health agency that provides care to you. We may share information with persons involved in your care, such as family members.

For Payment: We will use your protected health information to get paid for your healthcare services. We may share information with your insurance company to obtain payment for services or to seek pre-approval for a hospital stay or procedures.

For Our Healthcare or Business Operations: We may disclose your protected health information to support the business activities of this office, such as reviewing our care and our employees, for education and training, to support our electronic health record system, or for legal or accounting matters. We may use a sign-in sheet at the registration desk so that we may call you by name when we are ready to see you, and we may contact you to remind you of your appointment. If we involve third parties, such as billing services, in our business activities, we will have them sign a "business associate agreement" obligating them to safeguard your protected health information according to the same legal standards we follow.

When Allowed by Law: The law allows us to use or disclose your protected health information in certain situations, including:

- When required by state or federal law;
- To report abuse or neglect;
- To persons authorized by law to act on your behalf, such as a guardian, health care power of attorney or surrogate;
- For disaster relief purposes, such as to notify family about your whereabouts and condition;
- For public health activities such as reporting on or preventing certain diseases;
- To comply with Food and Drug Administration requirements;
- For health oversight purposes such as reporting to Medicare, Medicaid or licensing audits, investigations or inspections;
- Where required by U.S. Department of Health and Human Services to determine our compliance;
- In connection with Workers' Compensation claims for benefits; and
- To assist coroners or funeral directors in carrying out their duties.
- To comply with a valid court order, subpoena or other appropriate administrative or legal request if you are involved in a lawsuit or to assist law enforcement where there was a possible crime on the premises. We may also share your information where necessary to prevent or lessen a serious or imminent threat to you or another.
- If you are an inmate, we may release your information for your health or safety in the correctional facility; We may share your information with appropriate military entities if you are a member or veteran of the armed forces; We may be required to disclose information for national security or intelligence purposes.

With Your Authorization: Other uses and disclosures will be made only with your written authorization. For example, we will ask for your written permission before promoting a product or service to you for which we will be paid by a company, and generally

before sharing your health information in a way that is considered a sale under the law. If you sign an authorization, you may revoke it at any time, except where we have already shared your information based upon your permission.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to access, inspect and copy your protected health information.

- This usually includes medical and/or billing records. You must submit a written request to us, and you agree to pay the reasonable costs associated with complying with your request before we provide you with your record
- You may ask us to provide your electronic record in electronic format. If we are unable to provide your record in the format you request, we will provide the record in a form that works for you and our office. You may ask us to transmit your record to a specific person or entity by making a written, signed request.
- Under certain circumstances, your provider may not allow you to see or access certain parts of your record. You may ask that this decision be reviewed by another licensed professional.

You have the right to request to receive confidential communications, and request contact from us by **alternative means** or at an alternative location.

You have the right to request a restriction of your protected health information.

- This means you may ask us not to use or disclose all or part of your protected health information for certain purposes. We will consider your request carefully, and may honor reasonable requests where possible. The law does not require us to agree to every request.
- However, if you wish to restrict certain sensitive or other health information from your insurer after you or your personal representative have paid out of pocket in full for your services, please discuss this request with us. We will honor your request where we are not required by law to make the disclosure. If your insurance plan "bundles" your services together so that we cannot withhold only one item or service from your claim, we will discuss your options with you.
- You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to receive an accounting of certain disclosures we have made of your protected health information. Please speak with us if you have this request.

You may have the right to request amendment of your protected health information. While we cannot erase your record, we may add your written statement to your protected health information to correct or clarify the record where your provider approves. If the provider disapproves, you may submit a statement of disagreement and we may submit a rebuttal, which will remain with your record.

Breach notification. We are required to have safeguards in place that protect your health information. In the event that there is a breach of those protections, we will notify you, the U.S. Department of Health and Human Services and others, as the law requires.

You may file a complaint with us by notifying our Privacy Officer with your written complaint. We will not retaliate against you for filing a complaint with us or the Office of Civil Rights.

You may complain to the Office of Civil Rights at the Department of Health and Human Services (OCR) if you believe your privacy rights have been violated by us. You should contact the OCR in writing at:
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

If you have any questions about this notice, please contact:

Privacy Officer
White Mountain Community Health Center
298 White Mountain Highway
Conway, NH 03818
Phone: (603) 447-8900
Fax: (603) 447-4846

COMMUNICATION DIRECTIVE, CONSENT FOR TREATMENT,
INSURANCE AUTHORIZATION AND ASSIGNMENT: (Must be signed and dated before treatment.)

Name: _____ **Date of Birth:** _____

White Mountain Community Health Center uses a secure patient portal to provide you with convenient 24-hour access to your personal health information and medical records. Through the portal, you will be able to request refills, receive lab results, and communicate with your care team. Please provide your email: _____

Please Check ☒ and enter information for preferred method of contact:

- ☐ Home Phone _____
- ☐ Work Phone _____
- ☐ Cell Phone _____
- ☐ Mail _____
- ☐ Patient Portal (please provide email address) _____

Can messages be left at any of the above? Yes ☐ ***No*** ☐

Please list all individuals that may obtain your information, including *any* and *all* legal guardians if the patient is a minor or unable to consent.

Name_____	Relationship _____	Phone # _____
Name_____	Relationship _____	Phone # _____
Name_____	Relationship _____	Phone # _____
Name_____	Relationship _____	Phone # _____

1. CONSENT TO DIAGNOSTIC TESTS, PROCEDURES, AND TREATMENT:

I consent to care involving routine diagnostic tests, procedures, and treatment, including psychiatric care and the prescribing of medications as performed or ordered by the clinicians at the health center, including their assistants or designees, including testing for the human immunodeficiency virus (HIV) if a clinician is testing for diagnostic purposes or if there has been an exposure to health care personnel. No guarantee has been given to me as to the results that may be obtained from my care. If psychiatric medications are prescribed, I agree to discuss these medications with the psychiatrist to clearly understand their risks and potential benefits or alternatives.

Initial: _____

2. NOTICE OF PRIVACY PRACTICES:

By my signature below, I acknowledge that I have read and/or received and agree to the terms of the Notice of Privacy Practices and Patient Rights and Responsibilities from White Mountain Community Health Center. I also acknowledge that I have read and/or received and agree to the terms of the treatment agreement.

3. FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS:

I agree that I am responsible for payment of bills from White Mountain Community Health Center and designees. I have read and/or received a copy of the Summary of Payment and Billing Policy for the health center. I understand that I am solely responsible for collecting insurance claims or negotiating a settlement on all disputed claims. I also understand that any unpaid account may be assigned to an agency or attorney for collection, agree to the assignment of all third party payor benefits to the health center, its clinicians or providers.

I agree that a copy of this consent, release and assignment of benefits may be used in place of the original. I understand that I am entitled to a copy of same if I make such a request and that this consent release, and assignment are valid until rescinded in writing or replaced by one of a later date.

Patient Signature: _____ **Today's Date:** _____

The undersigned certifies that the patient is (unable to consent) (a minor) and the undersigned certifies that he/she has read and agrees to the above as the responsible party of the patient.

Responsible Party Signature _____ **Today's Date** _____

White Mountain Community Health Center Patient Registration

Services Requested

Services Requested: ☐ Medical ☐ Dental ☐ Behavioral health ☐ Substance use disorder treatment ☐ Other

Who is your preferred primary care provider (PCP)? _____

Patient Information

Last Name: _____ **First Name:** _____ **M.I.:** _____

Preferred/Nickname: _____ **Pronouns:** ☐ He/him ☐ She/her ☐ They/them ☐ Other: _____

Date of Birth: _____

Gender: ☐ Female (cis) ☐ Male (cis) ☐ Female (trans) ☐ Male (trans) ☐ Non-binary or other ☐ Decline to answer

Sex originally listed on your birth certificate: ☐ Male ☐ Female ☐ Decline to answer

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

☐ *Street address is the same mailing address.*

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #1: _____ ☐ Cell ☐ House ☐ Work **Phone #2:** _____ ☐ Cell ☐ House ☐ Work

I prefer appointment reminders by: ☐ Call ☐ Text **Ok to leave voicemail messages?** ☐ Yes ☐ No

Email address: _____

Preferred Pharmacy and Location: _____

Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired

Name of employer: _____

Have you ever served in the military? ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐ Other:_____

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other: _____ ☐ Prefer not to answer

Ethnicity: ☐ Hispanic/Latino/Latina ☐ Not Hispanic/Latino/Latina ☐ Prefer not to answer

Statistical information: As a Federally Qualified Health Center Look-Alike, White Mountain Community Health Center is required by federal law to collect the following information for statistical purpose only. Individual patient information is NOT reported or disclosed. Thank you for your cooperation.

Are you homeless? ☐ Yes ☐ No **Are you a migrant worker?** ☐ Yes ☐ No

Household Income $: _____ ☐ Weekly ☐ Monthly ☐ Yearly

Household Size *(Number of people in your household, including yourself)*: _____

Emergency Contact

Name: _____ **Relationship to Patient:** _____

Phone #1: _____ ☐ Home ☐ Cell ☐ Work **Phone #2:** _____ ☐ Home ☐ Cell ☐ Work

Payment and Insurance Information

Party responsible for payment: ☐ **Self (skip this section)** ☐ **Someone else**

Full name of person responsible for payment: _____

Relationship to patient: _____ **Date of birth:** _____

Phone #1: _____ ☐ Home ☐ Cell ☐ Work **Phone #2:** _____ ☐ Home ☐ Cell ☐ Work

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Patient Insurance Coverage: ☐ Uninsured ☐ Insured – Insurance: _____

☐ Please check here if the patient (or person responsible for payment) would like to meet with a staff member to discuss payment options or to determine if the patient is eligible for the Sliding Fee Discount Program. All patients, regardless of insurance status, are eligible to apply.

How did you hear about White Mountain Community Health Center?

☐ **Friend/relative**	☐ **Online search**	☐ **Emergency room**	☐ **Health insurer**
☐ **Sign/drive by**	☐ **Newspaper**	☐ **Health Center website**	☐ **Other:** _____
☐ **Community event**	☐ **Facebook**	☐ **I'm a former patient**	

New Patient Health Information

Do you have a living will? ☐ Yes ☐ No

Tell us who lives in your household: ☐ I live alone ☐ Children ☐ Other extended family ☐ Other ☐ Spouse/partner ☐ Parent(s) ☐ Roommate

How many children do you have? _____ **Children's ages:** _____

Current Medications & Supplements

Medication/Supplement	Dosage	Frequency	Medication/Supplement	Dosage	Frequency

Allergies

Please list any known allergies. Include any medication allergies, seasonal allergies, bees, shellfish, etc.

List what you are allergic to: What is your reaction?

_____ _____
_____ _____
_____ _____

Hospitalization

Have you ever spent the night in the hospital? If so, for what and when?

Date	Reason (Diagnosis)	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgical History

Have you ever had surgery? If so, for what and when?

Date	Reason (Diagnosis)	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Please list any diseases that your biological relatives have/had:

Father: _____ **Mother:** _____

Brother(s): _____ **Sister(s):**_____ **Son(s):** _____ **Daughter(s):**_____

Immunizations
(Include dates or attach immunization history)

☐ Flu (Influenza) _____
☐ Polio (OPV) _____
☐ Hepatitis B _____
☐ Hepatitis A _____
☐ Pneumonia _____
☐ Tetanus/Pertussis (Tdap/DTaP): _____
☐ Chicken Pox (Varicella): _____
☐ Measles, Mumps, Rubella (MMR) _____
☐ Shingles _____
☐ HPV _____
☐ Tuberculosis (TB) Test _____
☐ TB Vaccine (BCG) _____
☐ COVID _____
☐ Other: _____

Health Screening
(Please provide the date of your most recent screening)

- ☐ Physical Exam _____
- ☐ Cholesterol Check _____
- ☐ HIV Screening _____
- ☐ Hep C Screening _____
- ☐ Mammogram _____
- ☐ Pap Smear _____
- ☐ Colon Cancer Screening
  - ☐ Colonoscopy _____
  - ☐ Fecal Immunochemical Testing _____
  - ☐ Stool Test for Blood _____
- ☐ PSA Test/Prostate Cancer Screening _____
- ☐ Measles, Mumps, Rubella (MMR) _____

Current and Past Medical Conditions – Check all that apply

	Current	Past	Never		Current	Past	Never
Anemia	☐	☐	☐	Heart Murmur	☐	☐	☐
Angina	☐	☐	☐	Hemorrhoids	☐	☐	☐
Anxiety	☐	☐	☐	Hepatitis/Yellow Jaundice	☐	☐	☐
Asthma	☐	☐	☐	High Blood Pressure	☐	☐	☐
Bleeding Problems	☐	☐	☐	HIV	☐	☐	☐
Cancer of _____	☐	☐	☐	Kidney Disease	☐	☐	☐
Congestive Heart Failure	☐	☐	☐	Kidney Stones	☐	☐	☐
Chronic Bronchitis	☐	☐	☐	Pneumonia	☐	☐	☐
Depression	☐	☐	☐	Reaction to Anesthesia	☐	☐	☐
Diabetes	☐	☐	☐	Rheumatic Fever	☐	☐	☐
Emphysema/COPD	☐	☐	☐	Skin Disease/Dermatitis	☐	☐	☐
Gall Bladder Disease/Stones	☐	☐	☐	Stomach Ulcers	☐	☐	☐
Glaucoma	☐	☐	☐	Substance use disorder (alcohol or drug)	☐	☐	☐
Gout	☐	☐	☐	Thyroid Disease	☐	☐	☐
Hay Fever	☐	☐	☐	Tuberculosis/Positive PPD	☐	☐	☐
Head or Neck Radiation	☐	☐	☐	Vision Problems	☐	☐	☐
Hearing Difficulty	☐	☐	☐	Other: _____	☐	☐	☐
Heart Attack	☐	☐	☐	Other: _____	☐	☐	☐

If you answered "current" or "past" to any of the above, please describe and include dates:

Sexual & Reproductive Health Services

Are you sexually active? ☐ Yes ☐ No

Do you think of yourself as:
☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Queer, pansexual, and/or questioning ☐ Something else ☐ Don't know ☐ Decline to answer

How many pregnancies have you had? _____

How many live births have you had? _____

Do you need any of the following services today? Please check all that apply.

- ☐ Birth control
- ☐ Pregnancy testing
- ☐ STD testing
- ☐ HIV testing
- ☐ Pregnancy planning
- ☐ Referral for sterilization

AUTHORIZATON TO RELEASE AND DISCLOSE PATIENT INFORMATION

WHITE MOUNTAIN COMMUNITY HEALTH CENTER
Whole Person. Whole Family. Whole Valley.

Please print **PATIENT INFORMATION**	Name: _____ Date of Birth: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip: _____
WHO has the information you want released?	☐ Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____ Email: _____ **OR** ☐ **White Mountain Community Health Center, Conway, NH 03818 Phone: 603-447-8900 Fax: 603-447-4846** I hereby authorize the above named hospital/physician's office to: ☐ **Release medical records to** ☐ **speak/discuss with** ☐ **both release medical records to and discuss medical information with**
WHO do you want to receive your records?	☐ **White Mountain Community Health Center, Conway, NH 03818 Phone: 603-447-8900 Fax: 603-447-4846** **OR** ☐ Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____ Email: _____
INFORMATION TO BE RELEASED **WHAT** do you want shared? **CHECK** the appropriate boxes.	**Indicate date(s) of service: FROM: _____ TO: _____** **Type of Information** □ Entire Medical Record □ Immunization Record □ ER Notes □ Copy of Dental X-rays □ *Mental Health □ Verbal Exchange of Information □ Most Recent History and Physical □ Discharge Summary □ Genetic Testing □ Copy of Dental Chart □ Other: _____ **Type of Information** □ Progress Notes □ Laboratory Reports □ Radiology/Imaging Reports □ Consultations □ Operative Report □ Behavioral Health Treatment & Evaluation Records □ Drug Abuse/Treatment* □ HIV Diagnosis/Treatment* □ Alcohol Abuse/Treatment* ***Authorization to Release Protected Information** ☐ **I DO** authorize disclosure of any information relating to alcohol and/or drug abuse ☐ **I DO NOT** ☐ **I DO** authorize discloser of any information relating to diagnosis and or treatment of mental health ☐ **I DO NOT** ☐ **I DO NOT** want to review mental health information prior to being sent ☐ **YES, I WANT TO REVIEW** ☐ **I DO** authorize discloser of information which refers to HIV Test Results, Infection Status and/or treatment ☐ **I DO NOT**
PURPOSE OF RELEASE Why is this information needed?	☐ Continuing Care ☐ Transfer of Care ☐ Personal Use/Review ☐ Other: _____ **Fees may be charged in accordance with state and federal status**

I understand that:

- This authorization may be revoked in writing and delivered to WMCHC at any time, although revocation will not be effective as to the disclosure of records previously authorized and shared.
- Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining authorization and that I MAY REFUSE TO SIGN THIS AUTHORIZATION.
- Information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Accessing and obtaining your medical records is a requirement under 45 CFR 164.524 which requires that any request made to access or transfer medical records must be completed within **30 days** or a letter must be sent to the requestor stating why the records are delayed.

This authorization is effective for **1 year** from the date of signing. I authorize future disclosures to the same individual and/or entity during this time pursuant to this authorization.

_____ _____ _____

Signature of Patient or Authorized Representative | Date/Time | Printed Name