Winchendon Health Center
Member of the Heywood Healthcare Family

*David Havlin, M.D. / Medical Director*
*Aruna Adaikkalam, M.D.*
*Eliot Nottleson, PA*
*Carol Reich, F.N.P-BC,P.N.P-C*

# *Consent to Share Health Information*

Patient Name: _____ DOB: _____ Date: _____

The Winchendon Health Center, and all of its staff and physicians, are obligated to protect the health information of its' patients. The Winchendon Health Center takes its obligation to protect patient privacy very seriously and will only share your protected health information to authorized individuals when necessary. This disclosure identifies the most common situations and circumstances in which the Winchendon Health Center may provide health information about you to others.

Your health information may be shared with other healthcare providers who are involved in the care you receive at The Winchendon Health Center, and providers to whom your physician is referring you to for continued care or services. This is necessary in order to assure we are providing the appropriate care and services to meet your medical and healthcare needs.

Your health information may be shared with selected healthcare and medical professionals who are involved in the health center's operations. These individuals are required to maintain strict patient confidentiality and the health center has in place specific policies and procedures to monitor compliance with confidentiality.

Your health information may be shared with family members and friends only if you are present and able to give consent, or if you are in a situation where the medical provider, using his/her professional judgment, believes it is in your best interest.

If you would like to authorize the Winchendon Health Center's physicians and staff to release your medical information to others, please indicate the individual's name(s) below.

| Name | Date of Birth | Phone Number | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Please select which type of information you are authorizing for release:

____ All information
____ Billing Inquires
____ Medication Issues
____ Appointments
____ Diagnostic Testing Results

Expiration Date:

This authorization is valid for 12 months after the date signed, unless cancelled in writing. Please indicate if authorization is beyond 12 months or state (indefinitely) _____

_____ _____
Signature Date

Office Use Only *(last revised 7/13/2018)*
Consent Form Received By _____ Date _____