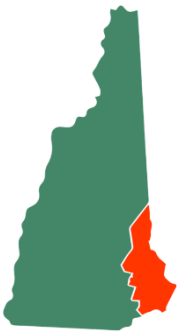
TripLink



BARRINGTON
BRENTWOOD
BROOKFIELD
DOVER
DURHAM
EAST KINGSTON
EPPING
EXETER
FARMINGTON
FREMONT
GREENLAND
HAMPTON
HAMPTON FALLS
KENSINGTON
KINGSTON
LEE
MADBURY
MIDDLETON
MILTON
NEW CASTLE
NEW DURHAM
NEWFIELDS
NEWINGTON
NEWMARKET
NEWTON
NORTH HAMPTON
NORTHWOOD
NOTTINGHAM
PORTSMOUTH
ROCHESTER
ROLLINSFORD
RYE
SEABROOK
SOMERSWORTH
SOUTH HAMPTON
STRAFFORD
STRATHAM
WAKEFIELD

AUTHORIZATION FOR
RELEASE OF MEDICAL INFORMATION

Dear Health Care Professional:

I have completed a TripLink Common Application and am applying for the following transportation services:

- ☐ COAST's ADA Paratransit Service
- ☐ COAST's Portsmouth Senior Transportation
- ☐ ACT's Community Rides

Part of this application process requires a health care professional to review the information I have provided and to make a determination of my functional ability. Eligibility for this service is a functional determination, not a medical one.

I hereby authorize you to provide this information by completing the Evaluation(s) of Functional Ability and submitting it directly to TripLink. Please read the instructions carefully, as the criterion for each service is different.

You are authorized to discuss this information with TripLink and the Cooperative Alliance for Seacoast Transportation (COAST).

Please complete all Evaluations of Functional Ability that are submitted to you by TripLink.

TripLink
42 Sumner Dr
Dover, NH 03820

Phone: 603-834-6010
Fax: 855-975-2546 (secure)
Email: TripLink@CommunityRides.org

Name: _____

Signature: _____ Date & Time: _____

Signature of Personal Representative: _____ Date: _____

Relationship to patient or authority to act for patient: _____

Term: Unless I otherwise revoke this authorization in writing, this authorization will automatically expire after the use or disclosure requested herein is made, unless otherwise specified.

Revocation: I understand that I may revoke this Authorization at any time by requesting it in writing. The revocation will be effective immediately upon your receipt of my written notice. I understand that the revocation will not have any effect on any action taken in reliance on this Authorization before it has received my written notice of revocation.

Potential for Redisclosure: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state Privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by my healthcare provider.

The Evaluation of Functional Ability must be completed by a Licensed or Certified:

Physician	Physician Assistant
Licensed Social Worker	Psychologist
Respiratory Therapist	Physical Therapist
Psychiatrist	Audiologist
Nurse Practitioner	Optometrist/Ophthalmologist
Registered Nurse	Case Manager/Worker
Occupational Therapist	

The completed *Authorization for Release of Medical Information* should be submitted to the health care professional or case worker listed below:

Name: _____

Agency: _____

Phone: _____

Fax: _____

Address: _____