

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

***** All Sections Must Be Completed For Valid Release *****

PATIENT INFORMATION

Name: _____ Date of Birth: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Phone: _____

Release Patient Information From:

- Elliot Health System Elliot Health Provider: _____
 Visiting Nurse Association of Manchester & Southern NH
 Southern New Hampshire Health Foundation Medical Partners Provider: _____
 Other Provider: _____

Release Patient Information To (Authorized Party):

- Elliot Health System Elliot Health Provider: _____
 Visiting Nurse Association of Manchester & Southern NH
 Southern New Hampshire Health Foundation Medical Partners Provider: _____
 Other Provider

Name of Individual: _____ Name of Entity: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone Number: _____ Fax Number: _____

PURPOSE OF REQUEST:

- Continuing Medical Care Legal Permanently Transfer to Another Provider
 Insurance Personal
 Inspect Record on site Other: _____

DATES OF SERVICE TO BE RELEASED:

From: _____ to _____

PATIENT INFORMATION TO BE RELEASED:

Check all that apply.

For sensitive information () you must also initial next to the information requested.*

- | | | |
|---|--|--|
| <input type="checkbox"/> ER | <input type="checkbox"/> H&P | _____ * HIV Diagnosis/Treatment |
| <input type="checkbox"/> Consult | <input type="checkbox"/> Operative Report | _____ * Mental Health |
| <input type="checkbox"/> Radiology | <input type="checkbox"/> Discharge Summary | _____ * Genetic Testing |
| <input type="checkbox"/> Lab | <input type="checkbox"/> Progress Note | _____ * Sexually Transmitted Disease (STD) |
| <input type="checkbox"/> Abstract | <input type="checkbox"/> Complete Medical Record | _____ Diagnosis/Treatment |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Clinical Photos | _____ ** Alcohol & Substance Use/Treatment |

****NOTE:** Alcohol and substance use and treatment records are protected by Federal Regulation 42 CFR Part 2. Federal rules prohibit any further re-disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

INFORMATION TO BE: Picked Up by *Authorized Party* Mailed to *Authorized Party*
 Faxed to *Authorized Party* (**See Fax Release Notice**)

Fax Release Notice: I am aware that by checking this box that I am authorizing the above requested information to be sent to the fax number that I have provided above. I am also aware of the risks associated with faxing protected health information, and *sensitive information, including but not limited to: erroneous transmission, lack of confidentiality safeguards at the site of the receiving machine, and incomplete transmission information. By checking this box, I acknowledge that I am accepting this risk.

PREFERRED FORMAT: Paper Electronic – CD Electronic – Flash Drive

COPY AND PROCEESING FEES:

There are currently no associated fees for patients to obtain copies of medical records for personal use. All other third-party requesters will be billed per the current State Fee Schedule.

I UNDERSTAND THAT:

- The information released pursuant to this authorization is confidential and must be used for the purpose that it was requested for; however, once this information is disclosed, the information may be subject to re-disclosure or release by the receiving party and may no longer be protected by federal and state confidentiality laws, unless protected by Federal Regulation 42 CFR Part 2 in which case it cannot be re-disclosed by the receiving party without my written authorization. I may revoke this authorization at any time in writing, provided the information has not already been disclosed in reliance on this authorization. Additional details may be found in the SolutionHealth Notice of Privacy Practices.
- This authorization is voluntary, and I may refuse to sign this form. I understand that refusing to sign this form will not affect my ability to obtain treatment, the payment for my treatment, or my enrollment or eligibility for benefits unless allowed by law.
- I have the right to revoke this authorization at any time and that I must contact the medical records department where I initially submitted my request in order to do so.
- This authorization is considered valid for a period of one year from the date of signature or until (date) _____.

SIGNATURE:

I have read this entire form or have had it read to me. I understand the content. I hereby authorize the release of my patient information stated above.

Patient/Parent/Legal Agent Signature

Date

Printed Name

Identification (if other than patient)

CONTACT INFORMATION:

Please mail or fax your request to the corresponding location:

Elliot Health System

Attention: Medical Records

One Elliot Way

Manchester, NH 03103

Telephone: (603) 663-2341

Fax: (603) 663-1856

Southern New Hampshire Health

Attention: Medical Records

8 Prospect Street, P.O. Box 2014

Nashua, NH 03061

Telephone: (603) 577-7500

Fax: (603) 577-5756