

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's full name _____ Date of birth _____ Medical Record number (if known) _____

I authorize _____ to:

Send/Disclose information to: Receive information from:

Name: _____ Phone #: _____
Address: _____ Fax #: _____

For the following purpose(s):

- Current treatment
- Personal records
- Insurance
- Workers' Comp.
- Attorney
- Provider transfer
- Other (specify): _____

Type of information requested:

Abstract (includes any available documents below or check only those documents needed):

- Discharge Summary
- Laboratory Report
- History & Physical
- Cardiology Report
- Consultation
- Radiology Report (Concord Hospital)
- Operative Report
- Radiology Report (Concord Imaging Ctr.)
- Emergency Dept. Documentation

Other health information:

- Physician Orders
- Progress Notes
- Radiology Films/CD (CD may include final report)
- Medication Records
- Other: _____
- Assessments
- Nurses' Notes
- Itemized Bill

Dates of care to be released: _____ to: _____

I UNDERSTAND THAT:

- Concord Hospital will treat me even if I decline to sign this authorization.
- Upon request, I can inspect or obtain a copy of the information I am authorizing to be released. A fee for the costs of processing this request may be charged.
- Once I authorize the disclosure of my health information, it is no longer considered protected information and re-disclosure by the recipient is legally permitted.
- Concord Hospital may utilize a trusted business associate to assist in fulfilling this request. If I have any questions about disclosure of my health information, I can contact the Release of Information staff of Health Information Management Services at Concord Hospital, 603-228-7312.
- I can revoke this authorization at any time by submitting a request in writing to the Concord Hospital Health Information Management Services or my physician's office. This will not apply to any previously released information. I understand that this will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- **The following types of information WILL BE INCLUDED UNLESS indicated by you initialing below:**

Drug and/or alcohol treatment	Initials: _____	Psychiatric	Initials: _____
Sexually transmitted disease	Initials: _____	Genetic testing	Initials: _____
HIV (AIDS) testing/treatment:	Initials: _____		

This authorization expires six months from the date of signature, or on: _____
I have been offered a copy of this form.

Sign Here →

Signature of patient or legal representative/ guardian

Date Here →

Authority or relationship of representative
(Attach copy of documentation of authority)

Date

Must be completed by hospital staff:

Date received: _____
 Request completed by: _____ (Name)
 Date completed: _____
 Delivery method: In person Mail Fax
 Other: _____

ID verified by: _____ (Name)
 ID method: Photo ID Personal recognition
 Demographic information match
 Other: _____