CONCORD HOSPITAL
Health Information Management Services

250 Pleasant Street Concord, NH 03301 (603) 228-7312 (603) 227-7518
concordhospital.org

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Information:

Name:______________________ Date of birth:______________________

Address:______________________ Phone number:______________________

City, State, Zip:______________________ Medical record number:______________________

I hereby authorize Concord Hospital/Concord Hospital Medical Group to:

Please choose one: ❑ Disclose my medical record information to: ❑ Obtain medical information from:

Name/Facility:______________________ Attention:______________________

Address:______________________ Phone number:______________________

City, State, Zip:______________________ Fax number:______________________

Purpose of request: ❑ Continuing care ❑ Personal records ❑ Insurance ❑ Workers' Comp. ❑ Attorney ❑ Provider Transfer
❑ Other:

Medical record information to be disclosed:

❑ Abstract (summary of documents for encounter)
❑ Discharge Summary
❑ History & Physical
❑ Consultation
❑ Operative Report
❑ Emergency Dept. Note
❑ Laboratory Report
❑ Cardiology Report
❑ Radiology Report (Concord Hospital)
❑ Radiology Report (Concord Imaging)
❑ Radiology Films/CD
❑ Physician Orders
❑ Progress Notes
❑ Medication Records
❑ Provider Office Notes
❑ Telephone Notes
❑ Other:
❑ Assessments
❑ Nurses' Notes
❑ Itemized Bill
❑ Immunization Record

Dates of care to be disclosed:

The following types of information WILL NOT BE INCLUDED without your permission. I authorize the following information to be disclosed by initialing:

Drug and/or alcohol treatment Initials:______________

Abuse/sexual abuse Initials:______________

Sexually transmitted disease Initials:______________

HIV (AIDS) testing/treatment Initials:______________

Psychiatric Initials:______________

Genetic testing Initials:______________

History of abortion: Initials:______________

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.
- Information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state laws.
- 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.
- However, I can revoke this authorization at any time by submitting a request in writing to the Concord Hospital Health Information Management Services or my provider'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.
- This authorization expires one year from the date of signature or on:

Signature:

______________________ ______________________ ______________________
Signature of patient or legal representative/guardian | Authority or relationship of representative | Date and Time

Request completed by ______________________ on ______________________.