CONCORD HOSPITAL

250 Pleasant Street, Concord, NH 03301
(603)225-2711 **www.concordhospital.org**

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT LABEL

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' Compensation ☐ Attorney
☐ Provider transfer ☐ Other (specify): _____

Type of information requested:

☐ Abstract (*includes any available documents below or check only those documents needed*):
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation
- ☐ Operative Report
- ☐ Emergency Dept. Documentation
- ☐ Laboratory Report
- ☐ Cardiology Report
- ☐ Radiology Report (Concord Hospital)
- ☐ Radiology Report (Concord Imaging Ctr.)

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

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.
- Information disclosed under this authorization might be redisclosed 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.
- 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.
- **The following types of information WILL BE INCLUDED UNLESS indicated by you initialing below:**

Drug and/or alcohol treatment	**Initials:** _____	**Psychiatric**	**Initials:** _____
Abuse/sexual abuse	**Initials:** _____	**Genetic testing**	**Initials:** _____
Sexually transmitted disease	**Initials:** _____	**History of abortion**	**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

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

Date/Time _____ Date/Time

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: _____

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