

218 East Road, Hampstead, NH 03841 603.329.5311

## **Authorization for Release of Protected Health/Medical Record Information**

Please print, fill out, and mail to: Health Information Dept. at the above address or fax to: 603-329-9460 Date of Birth: Patient: First MiddleLast Medical Record #: Address: Release: I hereby authorize Hampstead Hospital to use or disclose my protected health information in my medical record. Unless otherwise specified, an abstract of medical records will be copied which includes all pertinent information regarding services. A complete copy of the medical record may include, but is not limited to, the following: (please cross out and initial any items you do not want to release) Admission Assessments Progress Notes History and Physical Lab Data Consults Diagnostic Reports Discharge Summaries Nurses Notes **Behavior Support Plans** Other\_ I acknowledge and hereby consent, that the released information may contain alcohol/drug abuse treatment, psychiatric, HIV or AIDS, unless initialed. I do not consent \_\_\_\_\_(initials) Release To: Name of Person/Organization Authorized to receive copies Address Dates of Care included: to For the purpose of: \_\_\_\_ Personal \_\_\_\_ Insurance \_\_\_\_Attorney Physician Therapist \_\_\_\_ Other:\_ By signing this Authorization for Disclosure of Protected Health Information, I understand that: A photocopy or fax of this authorization shall be as valid as the original This Authorization for disclosure is not a required condition for treatment I understand that the recipient of information disclosed under this authorization may re-disclose this information, and the information may no longer be protected by federal or state confidentiality laws. Information disclosed may include psychiatric, substance abuse, HIV infection, AIDS, or tests for HIV Medical information may be disclosed via fax machine unless otherwise specified I understand that NH law permits Hampstead Hospital to charge for the cost of copying the information released under this authorization, up to \$15 for the first 30 pages or \$0.50 per page, whichever is greater. (NH RSA 151:21, X). It is my understanding that this information will be used or disclosed only for the purpose described above. I understand that I may revoke my authorization, in whole or in part, at any time, by written notice delivered to Hampstead Hospital's Health Information/Medical Record Dept., except to the extent Hampstead Hospital already has used or disclosed information in reliance on my authorization. Expiration Date: This authorization will expire on (Date) (Event) (If no date or event is stated, this authorization expires 90 days from the date signed.) **Date Signature Print Name** If not signed by patient, indicate authority or relationship (Durable Power of Attorney, Legal Guardian, Administrator or Executor *must submit evidence of appointment)* Date **WITNESS Signature Print Name**