HAMPSTEAD HOSPITAL

218 East Road, Hampstead, NH 03841
Ph: 603-329-5311 Fax: 603-329-9460

Authorization to Release Protected Health Information

Please print, complete, and mail to the Health Information Department at the above address or fax to 603-329-9460.

Patient: _____ **Date of Birth:** _____
Last First Middle
Address: _____ **Telephone:** _____

I authorize Hampstead Hospital to use and/or disclose my protected health information as described below for the purposes of:
☐ Continuing Medical Care ☐ Insurance ☐ Legal ☐ Personal ☐ Other: _____

Dates of Care to be Released: From: _____ To: _____ or ☐ Most recent admission/discharge

Release to: _____ _____
Name of Person Authorized to Receive Information Name of Entity Authorized to Receive Information
_____
Address
_____ _____
Telephone Fax

Information to be Released to the Above Person or Entity: *Check all that apply.*
☐ Record Abstract (Discharge Summary, History/Physical, Admission Assessments, Labs, Provider Progress Notes)
☐ Complete Medical Record ☐ Discharge Summary ☐ Psychiatric History ☐ Physical ☐ Admission Assessments
☐ Progress Notes ☐ Nursing Notes ☐ Labs ☐ Consults ☐ Behavior Support Plan ☐ Other: _____

By signing this authorization for the disclosure of protected health information, I understand that:

- A photocopy or fax of this authorization shall be as valid as the original.
- Hampstead Hospital will continue to treat me even if I decline to sign this authorization.
- I may request a copy of this signed authorization.
- The disclosed information might be re-disclosed and would no longer be protected by federal or state laws.
- Information may be disclosed via fax, unless otherwise specified.
- Information disclosed may include psychiatric, substance/sexual abuse, and STD and/or HIV diagnosis and/or treatment.
- I may inspect or obtain a copy of the protected health information described by this authorization. Per state law, the charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater.
- I may revoke this authorization in writing at any time by delivering such written revocation to the Health Information Department. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
- Information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. For substance use disorder patient records, disclosures of information are protected by federal confidentiality rule, 42 CFR Part 2. This rule prohibits recipients from making any further disclosure of information that identifies a patient as having received a substance use disorder diagnosis, treatment or referral to treatment unless further disclosure is permitted by written consent of the patient or as otherwise permitted by 42 CFR Part 2.

This authorization **will expire in 90 days** from the date of my signature below or on:_____.

Signature of Patient/Patient's Representative:	**Print Name:**
Relationship to Patient *(Submit Proof of Appointment)*:	**Date:**
Signature of Minor (Age 12-17):	**Print Name:**

Eff: 2003, R&R 9/13, 3/18, 12/19, 2/21, 1/22