Submit by Email Print Form

GREATER HAMPSTEAD FAMILY MEDICINE, PC
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH/MEDICAL RECORD INFORMATION

SS # _____ Chart Rec. # _____
Patient: _____ DOB: _____
Address: _____

A. General Release:
I hereby authorize _____ to disclose my protected health information in my medical record (except those subjects listed in Part B), which includes but is not limited to the following items:
Admission Assessments Consultations Progress Notes History and Physical Exams
Diagnostic Reports Discharge Summaries Lab Data/Reports Nurse Notes
Operative/Procedure Reports EKG's X-rays, Scans, etc. Mental Health Consultation
Other documentation relating sexually transmitted diseases
(To exclude a subject from release under this authorization, cross it out and write your initials next to it)

Previous provider's address: _____
_____

Note: This authorization does not apply to psychotherapy notes, which require a separate, specific release.

B. Special Releases:
I hereby authorize _____ to disclose the following protected health information:
_____ HIV – Related Illness, including AIDS
_____ Drug and/or Alcohol Abuse Treatment (see back of form for special notice)
[Write your initials next to the information that you want to release]

I understand that this information in Part B is protected by state and or/federal law and that I have the right to refuse to authorize its use or disclosure unless otherwise required by law. However, my initials indicate my authorization to the disclosure of this information.

RELEASE TO: Greater Hampstead Family Medicine, PC
PO Box 458
207 Stage Road
Hampstead, NH 03841

Dates of care included: _____ to _____
For the purpose of: _____ Request by Patient _____ Request by Parent

- I understand that GHFM, P.C., will not condition treatment on my providing this authorization and that I may refuse to sign this authorization, unless the treatment involves research or is performed only for the purpose of creating protected health information for disclosure to a third party (such as an insurance physical).

- 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.

It is my understanding that this information will be used or disclosed only for the purpose of described above. I understand that I may revoke my authorization at any time, by written notice delivered to above noted physician or facility except to the extent that physician or facility has disclosed information in reliance on my authorization.

EXPIRATION DATE: This authorization will expire on _____.
[If no date is stated, this expires ninety days from the date signed.]

_____ _____/_____
Date Signature/Print Name

_____
If not signed by patient, indicate authority or relationship

_____ _____/_____
Date Witness Signature/Print Name