Southern NH Internal Medicine Associates
6 Tsienneto Road Suite 300
Derry, NH 03038
Phone Number: (603)216-0400 Fax Number: (603)216-3800

Release of Protected Health Information

Patient Information
Name:_____Phone Number:_____

Address:_____ Zip Code:_____DOB:_____

Release Information To:_____

Address:_____

Phone Number:_____ Fax Number:_____

Release Information From:_____

Address:_____

Phone Number:_____Fax Number:_____

Patient Information To Be Released

___Complete Copy
___Radiology Results
___Lab Results
___Other (specify)_____
___Office Notes
___Immunization
___Cardiac

By signing my initials next to a category of highly confidential information listed below**, I specifically <u>DO NOT AUTHORIZE</u>** the use and/or disclosure of the type of highly confidential information indicated. If not indicted, my complete medical records will be used or disclosed pursuant to this authorization.

_____Information about a Mental Illness or Developmental disability
_____Information about HIV/AIDS Testing and/or Treatment
_____Information about Sexually Transmitted Disease
_____Information about Substance Abuse (ie: alcohol and/or drugs)
_____Information about Child Abuse and/or Neglect
_____Information about Genetic Testing

This authorization will remain in effect (please check one):

___From the date of this Authorization until the_____day of_____20_____
___Until one year (1) from the date signed

Purpose for which this information is being released (check one)

___Transfer of Care ___Attorney/Legal Case
___Insurance/Disability ___Continued Medical Care
___Personal Use

If transferring care, reason for leaving;_____

I understand that I may inspect or obtain a copy of the protected health information described by this authorization. I understand that Southern NH Internal Medicine Associates will not condition treatment, payment or (if applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure and that I may refuse to sign this authorization.
I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Office at Southern NH Internal Medicine Associates. 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.
I understand that information used or disclosed pursuant to this authorization could be subject to re-Disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. Requests for access to and copies of your medical information must be submitted to Southern NH Internal Medicine Associates by completing and signing this form.

****For copies of health information the practice charges $15.00 for the first 30 pages and $.50 for each additional page.****

I have read and understand the terms of the Authorization and I have had the opportunity to ask questions about the use and disclosure of health information. By signing the name below, I hereby, knowingly and voluntarily authorize Southern NH Internal Medicine Associates to use and disclose my PHI in the manner described above:

_____ _____
Signature of Patient **Date**

If the patient is a minor or is otherwise unable to sign this Authorization, the signature of a parent, guardian or other legal representative is required:

_____ _____
Signature of Personal Representative **Date**

_____ _____
Print Name **Relationship to Patient**

Copy provided: Southern NH Internal Medicine Associates shall provide a copy of this signed authorization to the patient if you request. This information has been disclosed to you from records

whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.
New Hampshire state law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease condition.