AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PERSONAL INFORMATION	
FIRST NAME:	LAST NAME:
DATE OF BIRTH:	**SOCIAL SECURITY NUMBER:**

Release Options

☐ Release records to Primary Care Physician (no charge).

☐ Release records at your request for a fee ($15 up to 30 pages + $.50 for each additional page).

RELEASE MEDICAL RECORDS TO			OBTAIN MEDICAL RECORDS FROM		
Name:			Name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone:	Fax:		Phone:	Fax:	

DATES OF RECORDS TO BE RELEASED				
☐ All Dates	☐ Specific Dates	☐ Date Range	From	To
PURPOSE OF RECORDS TO BE RELEASED				
☐ Transfer of Care	☐ Concurrent Care	☐ Personal Records	☐ Other	
SPECIFIC RECORDS TO BE RELEASED				
☐ All Records	☐ Ultrasounds	☐ Pap Smears	☐ Operative Reports	
☐ Laboratory Results	☐ Pathology Reports	☐ Bone Density Scan Report	☐ Other (Specify)	
☐ PCP Package Annual Exam Mammogram Pap Smear Lab Results		☐ Pregnancy Package ACOG Flowsheet Delivery Summary Ultrasounds Operative Reports		

I UNDERSTAND THAT

➡ Amoskeag Women's Health will treat me even if I decline to sign this authorization.

➡ 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 pursuant to **NH State Law Chapter 332-I section 332-I:1**.

➡ Once I authorize the disclosure of my health information, it is no longer considered protected information and re-disclosure by the recipient is legally permitted.

➡ I can revoke this authorization at any time by submitting a request in writing to Amoskeag Women's Health. 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. This authorization expires 12 months from the date of signature.

➡ The released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS treatment. The following types of information WILL BE INCLUDED UNLESS indicated by you initialing below:

☐ Drug ☐ Alcohol ☐ STD ☐ HIV ☐ Psychiatric ☐ Genetic

Date	Signature Patient/Representative	Relationship/Authority