

OB/GYN ASSOCIATES OF SOUTHERN NH

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION INCOMING

Patient Name:

Name: _____ DOB: _____

Address _____ Phone#: _____
Street City Zip

I request my medical records from:

Practice name: _____ Provider: _____

Address _____ Phone#: _____
Street City Zip

I authorize release of my Protected Health Information (PHI) to the following listed below:

**OB/GYN Associates of Southern NH
30 Daniel Webster Highway Suite 11
Merrimack, NH 03054**

Purpose of the release: Treatment _____; Other _____

Dates of Service: _____ to _____

____ Complete Copy of Medical Record ____ Office Notes ____ Lab Reports
____ Immunization Records ____ Growth Chart ____ X-Ray/Diagnostic Imaging Reports
____ Other (describe): _____

Please initial the following if applicable:

____ I specifically authorized the release of HIV/AIDS results
____ I specifically authorized the release of information in reference to drug and or alcohol abuse protected by Federal Regulation 42CFR
____ I specifically authorize release of psychiatric/neuropsychiatric record
____ I specifically authorize release of sexual assault/physical/verbal abuse record.

I understand that consent is subject to revocations at any time in writing except if the medical records have already been disclosed or if the authorization was signed as a condition of obtaining my insurance coverage as explained in St Joseph Healthcare's Notice of Privacy Practices.

I understand that if health information is disclosed by this authorization, it may no longer be protected under the terms of the privacy rules and the recipient may be able to legally re-disclose the health information to others.

This authorization expires 90 days from the date signed below or otherwise stated below:

Witness

Patient/Representative Signature

Date

Relationship to patient

Pursuant to NH Senate Bill 42, the fee for copies is \$15.00 for the first 30 pages and \$.50 for every page after

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