# OB/GYN ASSOCIATES OF SOUTHERN NH

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
**OUTGOING**

Name:_______________________________________________DOB:________________________

Address____________________________________________________Phone#:_______________
Street City Zip

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

Name: ________________________________________________________________________________

Address: _____________________________________________________________________________
Street City State Zip

Purpose of the release: Permanent Transfer______; Personal Copy ________ ; 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.

I have carefully read and understand the above statements. I hereby release SJ Physician Services from all legal responsibility or liability from the release of these medial records.

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*