

MERRIMACK VALLEY PEDIATRICS

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