

# LAMPREY HEALTH CARE

207 S. Main St. Newmarket, NH 03857 (603) 659-3106 x7253 FAX (603) 659-8003

128 State Route 27, Raymond, NH 03077 (603) 895-3351 FAX (603) 895-0773

Nashua Area Health Center, a Center for Lamprey Health Care ~ 10 Prospect Street, Suite 102, Nashua, NH 03060 ~ P (603) 883-1626

## Authorization to Use or Disclose Protected Health Information

NAME: \_\_\_\_\_  
Last First Middle Initial

DOB: \_\_\_\_\_ Telephone # (Home): \_\_\_\_\_ Work #: \_\_\_\_\_

- I will pick up my records  
 Please send my records to:

Please get my records from:

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

I authorize Lamprey Health Care to release the following records:

- All Records for last 3 years or most recent, to include: Patient Chart Summary, Office Notes, Immunizations, Imaging, Labs, Hospital reports, Consultation Notes, Pathology and GYN Records. \*If more than 3 years old: Colonoscopy, Cardiac Reports, PSA, Pap & Mammogram Records will be released.
- Physicals & Immunizations Only
- Only the following portion of Patient Record: \_\_\_\_\_

### For the purpose of:

Circle one: Insurance Attorney Personal Copy \*Transfer of Care

\*If Transferring please give a reason: \_\_\_\_\_

I understand that the information I have agreed to release may include but is not limited to **SENSITIVE** information such as: alcohol and drug use, child abuse/neglect, sexual assault/abuse, sexually transmitted diseases, termination of pregnancy, sexual preference, HIV, history of behavioral health, counseling/family problems. If you **DO NOT WANT** this information released, please state what is **NOT** to be released below:

### I understand these facts about the release of information by Lamprey Health Care:

1. Consent for release of information is not required as a condition of treatment.
2. This authorization may be revoked at any time except that information that has been disclosed prior to the date of revocation.
3. Only information necessary to fulfill the purpose(s) stated above may be released.
4. I understand that if I authorize disclosure of protected health information, the recipient may further disclose this information, and Federal law will no longer protect it.
5. I understand that I have the right to inspect or copy the information I am consenting to release. A copying fee may apply.
6. Once this authorization has expired we will no longer use or disclose your health information.
7. I am entitled to receive a copy of this signed authorization. I have received a copy **Initial here:** \_\_\_\_\_
8. I understand that information may be released by any acceptable means, including by fax.
9. This authorization will expire in 6 months (180) days from the date below or on: \_\_\_\_\_
10. A copy of this release is as valid as an original (e.g. fax).

\_\_\_\_\_  
Signature of Patient/Authorized Representative

\_\_\_\_\_  
Relationship if not patient

\_\_\_\_\_  
Date

I.D. checked? (Please Initial) \_\_\_\_\_ (e.g. Photo, College, Military I.D.)

### INTERPRETER'S STATEMENT:

I have translated the information on this form orally to the individual in \_\_\_\_\_ (language) and explained its contents to her/him. To the best of my knowledge and belief, she/he understood this explanation.

DATE: \_\_\_\_\_ Interpreter's Signature: \_\_\_\_\_

### For office use only:

Release of Records approved by: \_\_\_\_\_ Date: \_\_\_\_\_