

LAMPREY HEALTH CARE

Authorization to Use or Disclose Protected Health Information

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

NAME: _____
Last First Middle Initial

DOB: _____ Telephone # (Home): _____ Work #: _____

Please send my records to:

Please get my records from:

Name: _____ Telephone #: _____

Address _____
Street City State Zip Code

I authorize Lamprey Health Care to use or disclose the following Protected Health Information:

- | | |
|--|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> X-rays |
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> EKG |
| <input type="checkbox"/> Labs | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Pertinent Information from the last 2 years of care | <input type="checkbox"/> Information about an injury |
| <input type="checkbox"/> Other _____ | |

For the purpose of: _____

Treatment dates: _____

The information authorized for disclosure may relate to:

(Initial all that apply - without specific authorization, none of this information will be disclosed):

_____ Alcohol and or drug abuse _____ Psychiatric Care _____ HIV/AIDS

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

WITNESS: _____ 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: _____