LAMPREY
HEALTH CARE
Where Excellence and Caring go Hand in Hand

Authorization to Disclose Protected Medical Record Health Information

Patient Information:

Patient Full Name ***(please print)*** ____________________ **Previous Name if applicable** ____________________

Street Address ____________________ **Date of Birth** ____________________

City **State** **Zip Code** ____________________ **Daytime Phone #** ____________________

Receive Medical Records from:

Doctor/Organization Phone # Fax #

Street Address City State Zip Code

Information to be released:

____ Abstract of **last 3 years** or most recent to include: Chart Summary, Immunizations, Progress Notes, Imaging, Labs, Hospital Reports, Consultation Notes, Pathology, GYN Records, Colonoscopy, Cardiac Reports, PSA, Urology, Dermatology, Pap and Mammogram if more than 3 years old

____ Only some portion of the record (*please specify what to release*) ______________________________

Records to be sent to the office below: ***Please Check One:***

_______ **LHC-Nashua Center**
Attn: Medical Records
22 Prospect Street
Nashua, NH 03060
P: (603) 883-1626
F: (603) 881-9914

_______ **LHC-Newmarket Center**
Attn: Medical Records
207 So. Main Street
Newmarket, NH 03857
P: (603) 659-3106
F: (603) 659-8003

_______ **LHC-Raymond Center**
Attn: Medical Records
128 State Route 27
Raymond, NH 03077
P: (603) 895-3351
F: (603) 895-0773

Reason for release of records:

________Permanent Transfer Other (specify) ____________________

This authorization is valid for one year from date of signature and may be revoked by writing to the Organization listed above. My record may contain sensitive information (Alcohol and or drug use, STD, Behavioral Health) and I agree to this release. I have the right to receive a copy of this authorization. Records released pursuant to this authorization may be re-released and no longer protected by Federal Privacy Laws. Consent for release of information is not required as a condition of treatment.

This information has been disclosed to you from your records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who it pertains or otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

____________________ ____________________
Please print name of Patient or Authorized Representative Relationship if not Patient

____________________ ____________________
Signature of Patient/Authorized Representative Date