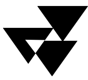


EXETER HOSPITAL
5 Alumni Drive Exeter, NH 03833 603.778.7311
www.exeterhospital.com

PATIENT ID OR LABEL

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION/MEDICAL RECORDS TO OTHER PARTY

Patient Name: (Last, First, Middle) | **Date of Birth:**

Patient Address: | **Phone Number:** ( ) -

City: | **State:** | **Zip:**

I Authorize Exeter Hospital To: (check one or more options below)

☐ ***RELEASE*** *Medical Records* ***TO:*** ☐ ***REQUEST*** *Medical Records* ***FROM:*** ☐ *Communicate Verbally With:*

Name: | **Attention:**

Address: | **Apt/Suite:** | **Phone Number** ( ) -

City: | **State:** | **Zip:**

Fax Number (Required for Urgent Continued Care Purposes): ( ) -

Records are Requested For the Purpose(s):
☐ Attorney ☐ Disability ☐ Insurance ☐ Physician ☐ Workers Compensation ☐ Other(Specify)____________________________

Medical Records Release/Request:

Dates of Care: From: **To:**

☐ **Standard Record Set*:** *See page 2 for details* **Exclude**:____

☐ **Other** (specify)____

**There may be a fee associated with your request, see page 2 for additional information*

If you would like something other than paper copies delivered by regular mail, please check the following options:

☐ I would like to pick up the requested records. (A representative will contact you when ready.)

☐ Radiology **Images and Report on CD** ☐ Radiology **Images (CD)** *and* above **medical records**

☐ Electronic copies of medical records in .pdf format*: *See page 2 for additional information*

(Check one) ☐ CD ☐ Email

*Requests for electronic delivery of medical records will be provided in secure format unless otherwise specified. Limitations may apply. A representative may contact you to discuss your request if necessary. In the event your request for electronic delivery cannot be accommodated, an alternative delivery method will be provided.

Email address:____

Specific Consent: *I consent to the release of information concerning HIV testing/results, genetic testing, and adoption. If you do not consent, initial here:* ____________

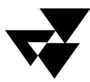
- I understand that signing this authorization is voluntary and that **I have the right to refuse to sign this authorization.** If I refuse to sign this authorization, **Exeter Hospital will not condition treatment** on my providing this authorization unless treatment involves research or is performed only for the purpose of creating protected health information for disclosure to a third party (e.g. insurance physical).
- I understand that that **I may revoke this authorization**, in whole or in part, at any time, by written notice delivered to Exeter Hospital Health Information Management department, except to the extent Exeter Hospital has already used or disclosed information in reliance on my authorization.
- I understand that the information used or disclosed under this authorization is confidential and must be used for the purpose described above and that the recipient of the information disclosed under this authorization **may re-disclose the information** and the information may no longer be protected by federal or state confidentiality laws.
- I understand that information may be released by acceptable means, including fax. Unless otherwise requested, records will be mailed using first-class United States Postal Service (USPS).

EXPIRATION DATE: This authorization **will expire in 90 days** from the date of my signature below or on: _________________.

Date Signed:	**Patient Signature:**

Print Name:____

If not signed by patient, indicate authority/relationship *and include evidence of appointment*:____________________________



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PATIENT ID OR LABEL

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION /MEDICAL RECORDS TO OTHER PARTY

PLEASE READ

- **Notice of Fees*: There **may be a charge for the cost of copying the records** released under this authorization in accordance to New Hampshire state law (NH RSA 151:21, X and NH RSA 332-I:1,I) or the HIPAA Privacy Rule (45 CFR 164.524). If you are requesting a complete copy of medical records it includes all documentation/reports which may be large in volume. Exeter Hospital may use a business associate to fulfill your requests for release of information in accordance with state and federal regulations.

- It is a violation of Federal and State law for a covered entity to release protected health information (PHI)/medical records to an unauthorized party. By signing this form you are affirming you are the person to whom the PHI you are asking to have access belongs to you or that you have the legal authority to release/request the information.

- ***Requests for Un-encrypted Medical Records in Electronic Format:** In the event you have requested un-encrypted (non-secure) medical records in electronic format, you are accepting the risk and releasing Exeter Hospital from all liability in the event your protected health information (PHI) is received or intercepted and subsequently accessed, re-disclosed, or acquired by another individual other than yourself. Media on CD or file attachments in an email could be accessed without a secure password and is otherwise accessible to anyone who has access to your postal mail or email account. Un-encrypted email can also be intercepted, or potentially misdirected and accessed or compromised by unauthorized individuals.

- ***Standard Record Set** includes all pertinent information from care received for dates requested to include all in-patient and out-patient provider care reports (e.g., Discharge Summary, Operative Reports, Emergency Room Reports, etc.) and any testing result reports (e.g., radiology, cardiology, laboratory, etc.). *Dates of Care* section must state actual date range. Terms such as "beginning", "end", "discharge", etc. are not accepted.

- Photo ID is required if medical records are being picked up. Medical records can only be released to the patient or individual authorized by the patient/legal representative.

- Be sure to write legibly and complete all sections on the authorization to avoid any delays.

- Please allow up to 30 days for the processing of your request for the release of medical records. See 45 CFR 164.524(b)(2). (In most cases records are available/provided within 1-10 days.)

- If you have been named as the Durable Power of Attorney for Health Care (DPOAHC) for a patient, you may request/authorize release of medical records *only* in the event the DPOAHC has been invoked by a Physician or Court (copy of the order is required if *not* invoked at Exeter Hospital)

- **You may submit this request for medical records to the Health Information Management (HIM) department via regular mail, hand-delivery, email at HIMROI@ehr.org, or by faxing to 603-580-6598. If you have additional questions or need assistance completing this form, please contact the HIM office at 603-580-6228.**