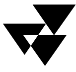

EXETER HOSPITAL
5 ALUMNI DRIVE • EXETER, NH 03833 • 603-778-7311

☐ **Patient Pick-up**
Date of Pick-up ________________

Appointment Date ________________

☐ **Mail-out**
Date of Mail-out ________________

DIAGNOSTIC IMAGING DEPARTMENT
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient:

Date: ________________ Telephone #: ________________________

Patient Name: ____________________________________ Date of Birth: ________________________

Destination of Films: Doctor/Facility: ____

Address: ____

____

____

Phone #: ____________________ Requested By: ________________________

Office Use:

DEPT	**REPORTS**	**DATE OF EXAM**	**EXAM TYPE (Please be specific)**

For the Purpose of: ☐ Request by Patient ☐ Other: ______________________________

- I understand that information may be released by any acceptable means, including by fax.
- I understand that Exeter Hospital will not condition treatment on my providing this authorization and that I may refuse to sign this authorization, unless the treatment involves research or is performed only for the purpose of creating protected health information for disclosure to a third party (such as an insurance physical).
- I understand that the recipient of information disclosed under this authorization may re-disclose this information, and the information may no longer be protected by federal or state confidentiality laws.
- I understand that New Hampshire law permits Exeter Hospital to charge for the cost of copying the information released under this authorization. There is no fee for the first set of copies requested, additional copies can be purchased at a cost of $5.00 per sheet. (NH RSA 151:21, X and NH RSA 332-I:1, I)

It is my understanding that this information will be used or disclosed only for the purpose described above. I understand that I may revoke my authorization at any time, by written notice delivered to Exeter Hospital's Medical Information Department, except to the extent Exeter Hospital already has used or disclosed information in reliance on my authorization.

EXPIRATION DATE: This authorization will expire on ________________ or ________________
Date *Event*

[If no date or event is stated, this authorization expires ***ninety days*** *from the date signed.]*

________________ ________________ / ________________
Date *Signature / Print Name*

____
If not signed by patient, indicate authority or relationship
[Durable Power Agent, Legal Guardian, Administrator or Executor; must submit evidence of appointment]

________________ ________________ / ________________
Date *WITNESS Signature / Print Name*

M.R.#: ________________/yr________ Staff Initials: __________ ☐ **To be Filed**

Form#213 (8/03)