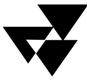

E X E T E R
H O S P I T A L
EXETER, NH 03833 • 603-778-7311

PATIENT ID OR LABEL

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH/MEDICAL RECORD INFORMATION

SS#____________________**Medical Rec.#**_______________

All highlighted areas must be completed.

Patient: ______________________________________ **Date of Birth:** ______________
Last First Middle

Address: ____

A. General Release: I hereby authorize Exeter Hospital to use or disclose my protected health information in my medical record (except those subjects listed in Part B). Unless otherwise specified, an abstract of medical records will be copied which includes all pertinent information regarding service (all dictated reports, diagnostic and lab data). A complete copy of the medical record includes, but is not limited to, the following items: (*please cross out and initial any items you do not want to release)*

Admission Assessments	Consultations	Progress Notes	History & Physical Exams
Diagnostic Reports	Discharge Summaries	Lab Data / Reports	Nurses' Notes
Operative/Procedure Reports	EKGs	Mental Health Consultation	
Information related to sexually transmitted diseases		Other (please specify):	____________

*Please check if you are requesting: ☐ Complete copy of chart ☐ Radiology films

B. Special Releases: (*Write your initials next to the information that you want to release)*

I hereby authorize Exeter Hospital to use or disclose the following protected health information.

_________ HIV-Related Illness, including AIDS ___________ Genetic Testing ___________ Adoption

_________ Drug and/or Alcohol Abuse Treatment (see back of form for special notice)

I understand that this information in Part B is protected by state and/or federal law and that I have the right to refuse to authorize its use or disclose unless otherwise required by law. However, my initials indicate my authorization to the use or disclosure of this information.

RELEASE TO: ____
(Name of Person / Organization Authorized to Receive Copies)

____
Address

Dates of Care Included: ______________________ to ______________________

For the Purpose of: ☐ Personal ☐ Insurance ☐ Attorney ☐ Physician ☐ 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, up to $15.00 for the first 30 pages or $.050 per page, whichever is greater. Charges for copies of filmed records (such as x-rays) will be at a reasonable cost. (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

PROHIBITION AGAINS RE-RELEASE OF INFORMATION

"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."