Foundation Medical Partners

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
(Medical Records)

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

I authorize Foundation Medical Partners to use, disclose, or release my protected health information (medical records) described below to:

Name/Entity: Nashua Adult Day Health

Address: 32 Daniel Webster Highway, unit 10 City: Merrimack State: NH Zip: 03054
(Note: Records will not be mailed if complete address is not supplied.)

Additionally, I authorize my provider and/or designee to discuss my records and treatment with the person/entity described below:

_____

Dates of care requested: 1-1-2018 → 1-1-2022 **Practice:** _____

____ Abstract (pertinent information related to your care, including all doctors notes, x-ray and lab reports)
____ Copy of the complete medical record ____ ED Record ____ Physical Therapy Notes
____ Discharge Summary ____ Surgical Report ____ Laboratory Reports
__✓__ History & Physical Report ____ Radiology Report ____ Other (specify) _____

Format Requested: (See page 2 for details) ____ Electronic CD ____ Paper __✓__ Fax 603-417-7113

Reason for Release: ____ Disability ____ Insurance ____ Legal ____ Transferring Care Other: Adult Day Program

If Transferring Care: ____ Dissatisfied with Service ____ Moving ____ Insurance Change Other: _____

If my initials appear below, I request that you do NOT send the following records:

_____, I do not authorize release of drug, alcohol abuse and/or psychiatric records. Federal Law 42 CFR Part 2 prohibits those receiving information on drug or alcohol treatment from re-disclosing it unless further disclosure is expressively permitted by written consent of the person to whom it pertains, or is otherwise permitted by 42 CFR Part 2.

_____, I do not authorize release of any records concerning my diagnosis of or treatment for HIV, AIDS or ARC, or contain some other reference to my identity as an HIV, AIDS or ARC patient for the purpose set forth above.

_____, I do not authorize the release of any records concerning genetic testing for the purposes set forth above.

I understand that I may inspect or copy the protected health information described in this authorization.

I understand that this authorization may be revoked in writing and delivered to the Medical Records Department of Foundation Medical Partners (399 Daniel Webster Highway, Merrimack, NH 03054) at any time, and that Foundation Medical Partners must cease using this authorization, except that Foundation Medical Partners may complete any actions it initiated in reliance on this authorization and prior to my revocation.

I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I understand that Foundation Medical Partners shall not condition treatment, payment or enrollment in the health plan or eligibility for benefits on my providing authorization for the requested used or disclosure and that I may refuse to sign this authorization.

I understand that by authorizing this release of my medical records I also release Foundation Medical Partners from all legal responsibility or liability that may arise from the release of these medical records.

DATE _____
(Authorizations without a date will not be processed)

_____
Signature of patient or representative

_____
Authority of representative (parent of minor, guardian, etc)
Copies may be attached of documentation

EXPIRATION: This authorization will expire on (date or event): _____. If no date or event is specified, the authorization shall expire six months from the date it was signed.
A copy of this authorization will be provided to the patient or representative if requested.

FMP OFFICE USE ONLY:

Format provided: ____ Electronic CD ____ Paper
Date provided: ____/____/_____
Fee paid: $_____