Southern New Hampshire **Medical Center**

southern new hampshire health

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (Medical Records)

Patient Name: ______________________ DOB: ____________ Phone: ____________

Address: ______________________ City: ____________ State: ____ Zip: ________

I authorize SNHMC to use, disclose, or release my protected health information (medical records) described below which may include information concerning treatment for drug or alcohol use, psychiatric treatment, HIV/AIDS/ARC status or genetic testing 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.)

For the following purpose: ("at patient request" is sufficient) ______________________

Dates of care requested: 1-1-18 → 1-1-2022

____ Abstract (pertinent information related to your care, including all doctors notes, x-ray and lab reports)
____ Copy of the complete medical record
____ Discharge Summary
✓ History & Physical Report
____ ED Report
____ Other (specify) ______________________

____ Surgical Report
____ Radiology Report
____ Physical Therapy Notes
____ Laboratory Reports

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

________, I do not authorize release of any records concerning drug or alcohol treatment and/or psychiatric treatment.

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

________, 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 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 Health Information Department of SNHMC (29 Northwest Boulevard, Nashua, NH 03063) at any time, and that SNHMC must cease using this authorization, except that SNHMC 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 SNHMC 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 SNHMC 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.