

**AUTHORIZATION TO RELEASE OR OBTAIN  
PROTECTED HEALTH INFORMATION (PHI)**



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Street Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

I authorize St Joseph Hospital to:  release my protected health information to the following listed below:  
and/or  obtain my protected health information from the following listed below:

Name: Nashua Adult Day Health  
Street Address: 32 DW Highway, unit 10 Phone #: 603-417-6656 Fax #: 417-7113  
City, State, Zip Code: Merrimack, NH 03054  
Dates of Service: 1-1-18 to 1-1-2022

**LOCATIONS:** Please select all St. Joseph Hospital (SJH) locations that apply to this release.  
 SJH Hospital  
 SJH Physician/Practice Names: \_\_\_\_\_

**GENERAL RECORDS** Preference for large records:  Paper  CD

<input type="checkbox"/> Discharge summary	<input type="checkbox"/> Emergency Room Record	<input type="checkbox"/> Pathology	<input type="checkbox"/> Office Notes
<input checked="" type="checkbox"/> History & Physical	<input checked="" type="checkbox"/> Facesheet	<input type="checkbox"/> Lab Results	<input type="checkbox"/> Growth Charts
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Xray Results (Report Only, Contact Xray for Films)	<input type="checkbox"/> Immunization Records
<input type="checkbox"/> Operation/Procedure Report	<input type="checkbox"/> Other (specify) _____		

**STATUTORILY PROTECTED OR SENSITIVE RECORDS**  
You must initial the following in order to specifically authorize the release of this information if applicable:

\_\_\_\_\_ Alcohol/Drug Abuse protected by Federal Regulation 42CFR      \_\_\_\_\_ Psychiatric/Neuropsychiatric Record  
\_\_\_\_\_ HIV/AIDS Results/Treatment      \_\_\_\_\_ Sexual Assault/Physical/Verbal Abuse Record

**THE PURPOSE OF THE RELEASE OF THIS INFORMATION IS FOR:**

Continuing Medical Care     Attorney/Legal Case     Personal Use     Employment     Worker's Comp.  
 Permanent Transfer     Disability/insurance Application/Claim     Other (specify) Adult Day Program

I understand that consent is subject to revocations at any time in writing to St. Joseph Hospital, except if the medical records have already been disclosed or if the authorization was signed as a condition of obtaining my insurance coverage as explained in St Joseph Hospital's Notice of Privacy Practices. I understand that if health information is disclosed by this authorization, it may no longer be protected under the terms of the privacy rules and the recipient may be able to legally re-disclose the health information to others. I have carefully read and understand the above statements. I hereby release St. Joseph Hospital from all legal responsibility or liability from the release of these medical records.

This authorization expires 90 days from the date signed below or other wise stated below:

_____	_____	_____	_____
Patient/Representative Signature	Date	Time	Relationship to patient
_____	_____	_____	
Witness	Date	Time	

**Pursuant to NH Senate Bill 42, the fee for copies is \$15.00 for the first 30 pages and \$.50 for every page after 172 Kinsley Street Nashua, New Hampshire 03061-2013 (603) 882-3000 ext 63898.**



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