

Health Information Management Services

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Information:

Name: _____ Date of birth: _____
Address: _____ Phone number: _____
City, State, Zip: _____ Medical record number: _____

I hereby authorize Concord Hospital/Concord Hospital Medical Group to:

Please choose one: Disclose my medical record information to: Obtain medical information from:
Name/Facility: _____ Attention: _____
Address: _____ Phone number: _____
City, State, Zip: _____ Fax number: _____
Purpose of request: Continuing care Personal records Insurance Workers' Comp. Attorney Provider Transfer
 Other:

Medical record information to be disclosed:

<input type="checkbox"/> Abstract (summary of documents for encounter)	<input type="checkbox"/> Physician Orders	<input type="checkbox"/> Assessments
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Laboratory Report	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Cardiology Report	<input type="checkbox"/> Medication Records
<input type="checkbox"/> Consultation	<input type="checkbox"/> Radiology Report (Concord Hospital)	<input type="checkbox"/> Provider Office Notes
<input type="checkbox"/> Operative Report	<input type="checkbox"/> Radiology Report (Concord Imaging)	<input type="checkbox"/> Telephone Notes
<input type="checkbox"/> Emergency Dept. Note	<input type="checkbox"/> Radiology Films/CD	<input type="checkbox"/> Other:
<input type="checkbox"/> Nurses' Notes	<input type="checkbox"/> Itemized Bill	<input type="checkbox"/> Immunization Record

Dates of care to be disclosed:

The following types of sensitive information WILL NOT BE INCLUDED without your permission.

I authorize the following information to be disclosed by initialing:

Drug and/or alcohol treatment	Initials: _____	Psychiatric	Initials: _____
Sexually transmitted disease	Initials: _____	Genetic testing	Initials: _____
HIV (AIDS) testing/treatment	Initials: _____	Other:	Initials: _____

I understand that:

- Concord Hospital will treat me even if I decline to sign this authorization.
- Upon request, I can inspect or obtain a copy of the information I am authorizing to be released. A fee for the costs of processing this request may be charged.
- Information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state laws.
- Concord Hospital may utilize a trusted business associate to assist in fulfilling this request. If I have any questions about disclosure of my health information, I can contact the Release of Information staff of Health Information Management Services at Concord Hospital, (603) 228-7312.
- I can revoke this authorization at any time by submitting a request in writing to the Concord Hospital Health Information Management Services or my provider's office. This will not apply to any previously released information. I understand that this will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- This authorization expires one year from the date of signature or on:

Signature:

Signature of patient or legal representative/guardian Authority or relationship of representative Date and Time