CONCORD HOSPITAL
Health Information Management Services

250 Pleasant Street Concord, NH 03301 (603) 228-7312 (603) 227-7518
concordhospital.org

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: Spaulding Academy & Family Services Attention: _____

Address: 72 Spaulding Rd. Phone number: 603-286-8901

City, State, Zip: Northfield, NH 03276 Fax number: 603-286-1254

Purpose of request: ☑ Continuing care ☐ Personal records ☐ Insurance ☐ Workers' Comp. ☐ Attorney ☐ Provider Transfer ☐ Other:

Medical record information to be disclosed:

☑ Abstract (summary of documents for encounter)

☐ Discharge Summary	☐ Laboratory Report	☐ Physician Orders	☐ Assessments
☐ History & Physical	☐ Cardiology Report	☐ Progress Notes	☐ Nurses' Notes
☐ Consultation	☐ Radiology Report (Concord Hospital)	☐ Medication Records	☐ Itemized Bill
☐ Operative Report	☐ Radiology Report (Concord Imaging)	☐ Provider Office Notes	☐ Immunization Record
☐ Emergency Dept. Note	☐ Radiology Films/CD	☐ Telephone Notes	
		☐ Other:	

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

Request completed by _____ on _____.