Foundation Medical Partners
southern new hampshire health

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: ____

Address: ____ City: _______________________ State: ______ Zip: __________
(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: ____ **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

Reason for Release: ____ Disability ____ Insurance ____ Legal ____ Transferring Care Other: _________________________________

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

EXPRIATION: 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: $___________________

INSTRUCTIONS FOR PATIENT REQUESTS

To Request a Copy of Your Medical Records:

- Fill out the authorization completely
- Authorizations must be dated in order to be processed.
- Present a valid photo ID with your request
- Timeframe (from the receipt of signed Authorization):
- Paper – 10 business days
- Electronic – 3 business days
- Foundation Medical Partners does not charge its patients a fee for a routine copy of your medical record. The below fees will be charged for certified copies or for repeated requests.
    - The fee, which is set by guidelines issued by the U.S. Department of Health and Human Services Office of Civil Rights, is $0.14 per page for paper copies or a flat fee of $6.50 for an electronic copy.
- Copies requested and sent directly to healthcare providers for ongoing treatment will continue to be provided free of charge.

Record Release Format Information and Clarification:

Electronic Copy

- An electronic copy of your health record will only include records created using our electronic medical record. It will not include any medical records created prior to the practice conversion to electronic medical records.

Paper Copy

- If you request a paper copy of your health record, it can include a printed copy of your electronic medical record as well as any medical records created prior to the practice conversion to electronic medical records.

Electronic & Paper Copy

- If you request your entire health record, it may include both paper and electronic copy.

Abstract

A record abstract contains immunizations, two years of office notes and labs, five years of radiology reports and five years of diagnostic reports.