The Elliot
A Member of SOLUTIONHEALTH

southern new hampshire health
A Member of SOLUTIONHEALTH

Home Health & Hospice Care
A Member of SOLUTIONHEALTH

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

****** All Sections Must Be Completed For Valid Release******

PATIENT INFORMATION

Name _____ Date of Birth:_____
Address: _____ City:_____ State:_____ Zip Code:_____
Phone: _____

Release Patient Information From:

☐ Elliot Health System ☐ Elliot Health Provider:_____
☐ Visiting Nurse Association of Manchester & Southern NH
☐ Southern New Hampshire Health ☐ Foundation Medical Partners Provider:_____
☐ Home Health & Hospice
☐ Other Provider:_____
_____
_____

Release Patient Information To (*Authorized Party*):

☐ Elliot Health System ☐ Elliot Health Provider:_____
☐ Visiting Nurse Association of Manchester & Southern NH
☐ Southern New Hampshire Health ☐ Foundation Medical Partners Provider:_____
☐ Other Provider
Name of Individual: _____ Name of Entity:_____
Address: _____
City: _____ State: _____ Zip Code:_____
Phone Number: _____ Fax Number: _____

PURPOSE OF REQUEST:

☐ Continuing Medical Care ☐ Legal ☐ Permanently Transfer to Another Provider
☐ Insurance ☐ Personal
☐ Inspect Record on site ☐ Other:_____

DATES OF SERVICE TO BE RELEASED:

From:_____ **To:**_____

PATIENT INFORMATION TO BE RELEASED: (Check all that apply.)

For sensitive information(*) you <u>must</u> also initial next to the information requested.

☐ ER
☐ Consult
☐ Radiology
☐ Lab
☐ Abstract
☐ Physical Therapy
☐ H&P
☐ Operative Report
☐ Discharge Summary
☐ Progress Note
☐ Complete Medical Record
☐ Clinical Photo
_____* HIV Diagnosis/Treatment
_____* Mental Health
_____* Genetic Testing
_____* Sexually Transmitted Disease (STD) Diagnosis/Treatment
_____* Other
_____** Alcohol & Substance Use/Treatment

EH042

***NOTE: Alcohol and substance use and treatment records are protected by Federal Regulation 42 CFR Part 2. Federal rules prohibit any further re-disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.*

INFORMATION TO BE: ☐ Secured email ☐ Mailed to *Authorized Party*
☐ Faxed to *Authorized Party* **(See Fax Release Notice)**

Fax Release Notice: I am aware that by checking this box that I am authorizing the above requested information to be sent to the fax number that I have provided above. I am also aware of the risks associated with faxing protected health information, and *sensitive information, including but not limited to: erroneous transmission, lack of confidentiality safeguards at the site of the receiving machine, and incomplete transmission information. By checking this box, I acknowledge that I am accepting this risk.

PREFERRED FORMAT: ☐ Paper ☐ My Chart ☐ Electronic – Flash Drive

COPY AND PROCESSING FEES:
There are currently no associated fees for patients to obtain copies of medical records for personal use, All other third-party requesters will be billed per the current State Fee Schedule.

I UNDERSTAND THAT:

- The information released pursuant to this authorization is confidential and must be used for the purpose that it was requested for; however, once this information is disclosed, the information may be subject to re-disclosure or release by the receiving party and may no longer be protected by federal and state confidentiality laws, unless protected by Federal Regulation 42 CFR Part 2 in which case it cannot be re-disclosed by the receiving party without my written authorization. I may revoke this authorization at any time in writing, provided the information has not already been disclosed in reliance on this authorization, Additional details may be found in the SolutionHealth Notice of Privacy Practices.
- This authorization is voluntary, and I may refuse to sign this form. I understand that refusing to sign this form will not affect my ability to obtain treatment from SolutionHealth, the payment for my treatment, or my enrollment or eligibility for benefits unless allowed by law.
- I have the right to revoke this authorization at any time and that I must contact the medical records department where I initially submitted my request in order to do so.
- This authorization is considered valid for a period of one year from the date of signature or until (date)_____.

SIGNATURE:
I have read this entire form or have had it read to me. I understand the content. I hereby authorize the release of my patient information stated above and release SolutionHealth from any legal responsibility or liability relating to the release of information.

_____ _____
Patient/Parent/Legal Agent Signature Date

_____
Printed Name

_____
Identification (if other than patient)

CONTACT INFORMATION:
Please mail or fax your request to the corresponding location:

Elliot Health System
Attention; Medical Records
One Elliot Way
Manchester, NH 03103
Telephone: (603) 663-2341
Fax: (603) 663-1856

Southern New Hampshire Health
Attention: Medical Records
8 Prospect Street, P.O. Box 2014
Nashua, NH 03061
Telephone: (603) 577-7500
Fax: (603) 577-5756