HAMPSTEAD HOSPITAL

218 East Road, Hampstead, NH 03841
Ph: 603-329-5311 Fax: 603-329-9460

Authorization to Release Protected Health Information

Please print, complete, and mail to the Health Information Department at the above address or fax to 603-329-9460.

Patient: _____ **Date of Birth:** _____ **Medical Record #:** _____
Last First Middle
Address: _____ **Telephone:** _____

I hereby authorize Hampstead Hospital to use and/or disclose my Protected Health Information in my medical record. Unless otherwise specified, an abstract of medical records will be copied, which includes all pertinent information regarding services. A complete copy of the medical record may include, but is not limited to, the following: *(If applicable, please cross out and initial any items you do not want released).*

Psychiatric History Physical Admission Assessments Progress Notes Nursing Notes
Labs Consults Behavior Support Plan Discharge Summary Other: _____

Release to: _____ _____
Name of Person Authorized to Receive Information Name of Entity Authorized to Receive Information
_____
Address
Dates of Care included: _____ to _____.
For the Purpose of: _____ Personal _____Insurance _____ Attorney _____ Physician _____ School
_____ Therapist _____ Other: _____

By signing this authorization for the disclosure of Protected Health Information, I understand that:

- A photocopy or fax of this authorization shall be as valid as the original.
- Information may be disclosed via fax, unless otherwise specified.
- Information disclosed may include psychiatric and/or substance use or HIV/AIDS results and/or treatment (if applicable).
- I may inspect or obtain a copy of the Protected Health Information described by this authorization. Per state law, the charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater.
- Hampstead Hospital will not condition treatment, payment or (if applicable) enrollment in a health plan or eligibility for benefits, on my providing authorization for the requested use or disclosure **and that I may refuse to sign this authorization.**
- I may revoke this authorization in writing at any time by delivering such written revocation to the Health Information Department. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
- 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. For substance use disorder patient records, disclosures of information are protected by federal confidentiality rule, 42 CFR Part 2. This rule prohibits recipients from making any further disclosure of information that identifies a patient as having received a substance use disorder diagnosis, treatment or referral to treatment unless further disclosure is permitted by written consent of the patient or as otherwise permitted by 42 CFR Part 2.

This authorization will expire on _____ or _____.
Date Event
(If no date or event is stated, this authorization expires 90 days from the date signed.)

____/____ /____ _____ _____
Date Signature Print Name

If not signed by patient, indicate authority or relationship to patient. Durable Power of Attorney, Legal Guardian, Administrator or Executor must submit proof of appointment.

_____
Relationship to Patient

____/____ /____ _____ _____
Date Signature of Witness Print Name

Eff: 2003, R&R 9/13, 3/18, 12/19, 2/21