AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ______________________ DOB: ______________

Street Address: ______________________ Phone #: ______________

City, State, Zip Code: ______________________

I authorize St Joseph Hospital to: ☐ **release my protected health information to the following listed below:**
and/or ☐ **obtain my protected health information from the following listed below:**

Name: ______________________

Street Address: ______________ Phone #: __________ Fax #: __________

City, State, Zip Code: ______________________

Dates of Service: ______________ to ______________

LOCATIONS: Please select all St. Joseph Hospital (SJH) locations that apply to this release.

☐ SJH Hospital

☐ SJH Physician/Practice Names: ______________________

GENERAL RECORDS Preference for large records: ☐ Paper ☐ CD

☐ Discharge summary
☐ History & Physical
☐ Consultation Reports
☐ Operation/Procedure Report
☐ Emergency Room Record
☐ Facesheet
☐ Physical Therapy
☐ **Other (specify)** ______________________
☐ Pathology
☐ Lab Results
☐ Xray Results (Report Only, Contact Xray for Films)
☐ Office Notes
☐ Growth Charts
☐ Immunization Records

STATUTORILY PROTECTED OR SENSITIVE RECORDS
You must initial the following in order to specifically authorize the release of this information if applicable:

________ Alcohol/Drug Abuse protected by Federal Regulation 42CFR
________ HIV/AIDS Results/Treatment
________ Psychiatric/Neuropsychiatric Record
________ Sexual Assault/Physical/Verbal Abuse Record

THE PURPOSE OF THE RELEASE OF THIS INFORMATION IS FOR:

☐ Continuing Medical Care
☐ Permanent Transfer
☐ Attorney/Legal Case
☐ Disability/insurance Application/Claim
☐ Personal Use
☐ Employment
☐ Worker's Comp.
☐ **Other (specify)** ______________

I understand that consent is subject to revocations at any time in writing to St. Joseph Hospital, except if the medical records have already been disclosed or if the authorization was signed as a condition of obtaining my insurance coverage as explained in St Joseph Hospital's Notice of Privacy Practices. I understand that if health information is disclosed by this authorization, it may no longer be protected under the terms of the privacy rules and the recipient may be able to legally re-disclose the health information to others. I have carefully read and understand the above statements. I hereby release St. Joseph Hospital from all legal responsibility or liability from the release of these medical records.

This authorization expires 90 days from the date signed below or other wise stated below:

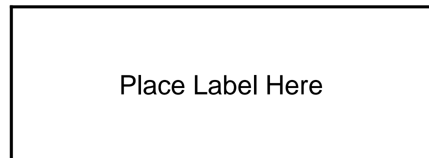
____

______________________ Patient/Representative Signature ________ Date ________ Time ______________________ Relationship to patient

______________________ Witness ________ Date ________ Time

Pursuant to NH Senate Bill 42, the fee for copies is $15.00 for the first 30 pages and $.50 for every page after

172 Kinsley Street Nashua, New Hampshire 03061-2013 (603) 882-3000 ext 63898.



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RELEASE OF INFORMATION