PERMISSION TO SPEAK / AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION:

Patient Name: ________________________________ Date of Birth: ____________________

___**Not At This Time:** I decline to name family members and/or other individuals with whom SJH may discuss my health information at this time. However, I understand that I may provide verbal authorization to my SJH providers to discuss my health information and they will do so in their professional judgment. Additionally, I understand that I may complete this form at a later date.

___**Authorization To Discuss My Health Information:** I authorize St. Joseph Hospital and St. Joseph Hospital Physician Practices Associates, providers, and staff (hereinafter referred to as SJH) to discuss my health information with the family members and/or other individuals named below. I understand this permission includes all of my health information, except as restricted below. This Authorization specifically includes, but is not limited to, permission for the named individuals to learn about my diagnosis, prognosis and treatment plans, ask questions about my health information, make and confirm appointments on my behalf with SJH, pick-up medication and orders from SJH, and have access to my SJH financial information.

Name:____________________ Relationship:____________________ Primary Tel. No.: ______________

Name:____________________ Relationship:____________________ Primary Tel. No.: ______________

Name:____________________ Relationship:____________________Primary Tel. No.: ______________

Please note that the following types of health information/treatment shall be EXCLUDED from discussions UNLESS I have expressly authorized permission by initialing below:

______Behavioral Health _______HIV/AIDS _______ Drug or Alcohol Abuse ______ Sexually Transmitted Disease

I understand that this Authorization applies across St. Joseph Hospital and St. Joseph Physician Practices, which are listed at: http://www.stjosephhospital.com.

I understand that SJH shall not condition treatment on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.

I understand that I may revoke, update, or change this Authorization at any time in writing. Any termination of or change to this Authorization shall be effective on the date received by my SJH providers, and I understand that any termination or revocation does not apply to information released prior to then.

ST. JOSEPH
HOSPITAL
Nashua, NH 03060

Place Label Here

PERMISSION TO SPEAK / AUTHORIZATION TO DISCUSS
PROTECTED HEALTH INFORMATION:

I understand that once my information is shared with the individual(s) named above, it could be subject to re-disclosure by the recipients and, if so, may not be subject to federal or state law protecting its confidentiality. I understand that SJH cannot prevent these individuals from sharing my information with third parties, and therefore, I absolve SJH for breach of confidentiality in the circumstances specifically stated.

I understand that no copies of my health information or medical records will be given unless I separately execute an "Authorization to Release or Request Protected Health Information" form.

EXPIRATION DATE: This Authorization is valid for one year.

Patient or Representative Signature: ______________________ Date: __________ Time: __________

Relationship of Representative: ______________________

If applicable
COPY PROVIDED: If requested, SJH shall provide a copy of this signed Authorization to the subject individual.