

Partners for Women's Health, PA

AUTHORIZATION TO RELEASE MEDICAL RECORDS

As required by the Health Insurance Portability and Accountability Act of 1996(HIPPA), this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

PHONE #: _____ ALT #: _____

PLEASE OBTAIN INFORMATION FROM:

Name of Provider/Clinic/Organization

Street Address

City, State, Zip

Phone

Fax

PLEASE SEND INFORMATION TO:

Partners for Women's Health, PA
3 Alumni Dr. Suite 401
Exeter, NH 03833

Phone 603-778-0557 Fax 603-778-1669

I authorize the following information to be disclosed:

_____ Pap Smear (most recent) _____ Pathology Reports _____ Operative reports _____ Mammogram _____ OB records only

_____ **Last 2 years** of GYN medical records

_____ Other- Specific dates/information _____ Date(s) _____ Items to release _____

My record may include sensitive material such as HIV, STD, mental health and alcohol/substance abuse. I agree to release this information unless specified here _____

REASON for disclosure of health information: (please **initial** reason for release – **must** be indicated on form)

_____ New Primary Care _____ Transfer from practice _____ staying with practice _____ Other(specify) _____

NOTE: If these records contain any information from previous providers or information about HIV/AIDS status, cancer, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

This authorization will expire in one year. You have the right to revoke prior to one year by providing the practice a written notice of revocation.

I am the: (please **check** one)

_____ Patient _____ Parent/Guardian _____ Person/Entity (describe specifically) _____

Signature of Patient (or Parent/Guardian, or Person/Entity)

Date

Printed Name of Patient (or Parent/Guardian, or Person/Entity)

Refusal to Sign Authorization

I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form. I understand that I may revoke this authorization at any time by notifying this medical practice in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken by this medical practice prior to its receipt. I understand that, if the recipient of the information is not a health care provider or plan covered by HIPPA, the information used or disclosed or described above may be re-disclosed by the recipient and no longer practiced by HIPPA. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV and AIDS-related information, and psychiatric/mental health information.

I understand that NH law permits Partners for Women's Health to charge for the cost of copying the information release under this authorization up to \$15 for the first 30 pages or \$.50 page, whichever is greater. (NHRSA 332-L:1)