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:

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

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

PLEASE SEND INFORMATION TO:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip

_____ _____
Phone Fax

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 (We do not need entire record)

_____ 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:

_____New Primary Care _____Transfer from practice _____Copy for myself/ Legal representative ____ 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)