AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH MEDICAL RECORD INFORMATION

CONTACT FOR LAMPREY HEALTH CARE: ALL SITES

Fax (833) 953-3701 * Phone (603) 895-3351 option 7 * Mail: 128 State Route 27, Raymond, NH 03077

PATIENT REQUEST:

Patient Name: (Please Print) DOB: Phone:

I AUTHORIZE LAMPREY HEALTHCARE TO: Check one: **RELEASE TO** ☐ **OR** **OBTAIN FROM** ☐

To/From: Name of Person or Organization Phone: Fax:

Full Address:

Check one: ☐ **SEND** ☐ **VERBAL** ☐ **FAX** ☐ **ELECTRONIC** **PICK UP IN**: ☐ **Nashua** ☐ **Newmarket** ☐ **Raymond**

- Consent for the release of information is not required as a condition of treatment.
- This authorization may be revoked at any time in writing except that information that has been disclosed prior to the date of revocation. Please contact the Privacy Officer at the address listed above.
- Only information necessary to fulfill the purpose(s) stated below may be released.
- I understand that if I authorize disclosure of protected health information, the recipient may further disclose this information, and Federal law will no longer protect it.
- I understand that I have the right to inspect or copy the information I am consenting to release. A copying fee may apply.
- I am entitled to receive a copy of this signed authorization. I have received a copy Initial here:
- I understand that information may be released by any acceptable means, including by fax.

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INFORMATION TO BE RELEASED / OBTAINED: (*Please check all that apply below)*

☐ Abstract of last 3 years or most recent to include: Facesheet, Encounters, Vaccines, Imagings, Labs, Hospital reports, Consult notes, Pathology and GYN records. ***more than 3 years old:** Colonoscopy, Cardiac reports, PSA, Pap and Mammogram will be released.

☐ Physical and immunizations (health form) ☐ Other (*Please specify*)

For the Following Reason: ☐ Transfer of Care ☐ Attorney ☐ Insurance ☐ Personal Other:

If Transferring please give reason:

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I understand that the information I have agreed to release may include the following SENSITIVE information: Please initial the sensitive information we are permitted to release in the spaces provided:

☐ **Substance Use Disorder Treatment records**	☐ **Genetic Testing**
☐ **Behavioral Health Treatment records**	☐ **Sexually Transmitted**
☐ **Sexual Assault/Child Abuse**	☐ **HIV/AIDS Test Results**

I authorize Lamprey Healthcare to release my information for Treatment, Payment, or Healthcare Operations:

☐ By checking this box I understand this release shall never expire.

☐ By checking this box I would like this release to expire on

If neither box is checked above, this release will expire one year from the date signed below.

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This information has been disclosed to you from your records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who it pertains or otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Date:

Signature of Patient or Authorized Representative Relationship if not patient

INTERPRETER'S STATEMENT: I have translated the information on this form orally to the individual in (language) and explained its contents to her/him. To the best of my knowledge and belief, she/he understood this explanation.

Interpreter's Signature: DATE: