CONCORD HOSPITAL | Laconia

80 Highland Street Laconia, NH 03246 (603) 524-3211
concordhospital-laconia.org

Authorization to Disclose Protected Health Information

Patient name:_____ Medical Record No.:_____

Address:_____ Date of birth:_____

_____ Phone number:_____

I authorize

Name of facility/health care provider:_____

Address:_____ Phone number:_____

To disclose my information to: Concord Hospital—Laconia, 80 Highland Street, Laconia, NH 03246
Phone: (603) 524-3211 x3314 Fax: (603) 527-7190

For the purpose(s):

☐ Current treatment ☐ Personal records ☐ Insurance ☐ Worker's Compensation
☐ Provider transfer ☐ Attorney ☐ Other:_____

Date(s) of service:_____

Information to be disclosed:

☐ Abstract (includes all items from the below list or check only those documents needed):

☐ Emergency Dept. Documentation ☐ Discharge Summary ☐ History & Physical
☐ Consultation ☐ Laboratory Report ☐ Imaging report
☐ Progress Notes ☐ Imaging CD ☐ Medication Reports
☐ Operative Report ☐ OT/PT Reports ☐ Office Notes
☐ Immunizations: ☐ Other:_____

The following types of information WILL BE INCLUDED UNLESS indicated by your initialing below:

Drug and/or alcohol treatment Initials:_____ Psychiatric Initials:_____
Abuse/sexual abuse Initials:_____ Genetic testing: Initials:_____
Sexually transmitted diseases Initials:_____ History of abortion Initials:_____
HIV (AIDS) testing/treatment: Initials:_____

I understand that:

- Upon request, I can inspect or obtain a copy of the information I am authorizing to be release. A fee for the costs of processing this request may be charged.
- Information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state laws.
- Concord Hospital--Laconia may utilize a trusted business associate to assist in fulfilling this request. If I have any questions about disclosure of my health information, I can contact the Release of Information staff of Health Information Management Services at (603) 524-3211 x3314.
- I can revoke this authorization at any time by submitting a request in writing to the Health information Management Services or my provider's office. This will not apply to any previously released information. I understand that this will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization expires six months from the date of signature, or on:_____
I have been offered a copy of this form.
This form must be fully completed before signing.

_____ _____

Signature of patient or legal representative/guardian Date Time

_____

Authority or relationship of representative

Revised 10/2019