CONCORD HOSPITAL | Franklin

15 Aiken Avenue Franklin, NH 03235 (603) 934-2060
concordhospital-franklin.org

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Information:

Name:_____ Date of birth:_____

Address:_____ Phone number:_____

City, State, Zip:_____ Medical record number:_____

I authorize Concord Hospital—Franklin to:

Please choose one: ❑ Disclose my medical record information to: ❑ Obtain medical information from:

Name/Facility:_____ Attention:_____

Address:_____ Phone number:_____

City, State, Zip:_____ Fax number:_____

Purpose of request: ❑ Continuing care ❑ Personal records ❑ Insurance ❑ Workers' Comp. ❑ Attorney ❑ Provider Transfer ❑ Other:

Medical record information to be disclosed:

❑ Abstract (summary of documents for encounter)		❑ Physician Orders	❑ Assessments
❑ Discharge Summary	❑ Laboratory Report	❑ Progress Notes	❑ Nurses' Notes
❑ History & Physical	❑ Cardiology Report	❑ Medication Records	❑ Itemized Bill
❑ Consultation	❑ Radiology Report (Concord Hospital)	❑ Provider Office Notes	❑ Immunization Record
❑ Operative Report	❑ Radiology Report (Concord Imaging)	❑ Telephone Notes	
❑ Emergency Dept. Note	❑ Radiology Films/CD	❑ Other:	

Dates of care to be disclosed:

The following types of sensitive information WILL NOT BE INCLUDED without your permission. I authorize the following information to be disclosed by initialing:

Drug and/or alcohol treatment Initials:_____ **Psychiatric** Initials:_____

Sexually transmitted disease Initials:_____ **Genetic testing** Initials:_____

HIV (AIDS) testing/treatment Initials:_____ **Other:**_____ Initials:_____

I understand that:

- Concord Hospital—Franklin will treat me even if I decline to sign this authorization.
- Upon request, I can inspect or obtain a copy of the information I am authorizing to be released. 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 Concord Hospital--Laconia, (603) 524-3211, ext. 3314.
- I can revoke this authorization at any time by submitting a request in writing to the Concord Hospital--Laconia 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 one year from the date of signature or on:

Signature:

_____	_____	_____
Signature of patient or legal representative/guardian	Authority or relationship of representative	Date and Time

Request completed by _____ on _____.