# Patient Information Form

## Please Print Clearly

**If needed, please ask for assistance in completing this form.**

Patient Name: _____ Date of Birth: _____ (Month / Day / Year)

List any different name(s) you've used, such as a maiden name: _____

Street: _____ P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ (check one) → Cell ☐ Home ☐ Work ☐

Secondary Phone: _____ (check one) → Cell ☐ Home ☐ Work ☐

Email Address: _____

I authorize Lamprey Health Care to communicate with me using email: ☐ Yes ☐ No

Gender assigned at birth: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner

Employment Status: ☐ Full Time ☐ Part Time ☐ Disabled ☐ Unemployed ☐ Retired (date): _____ Employers Name: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Relationship: _____

**If the patient is a child, please complete this section.**

**Parent/Guardian #1 Name:** _____

Date of Birth: _____ (Month / Day / Year) Relation to patient: _____

Address (if different from patient): _____

**Parent/Guardian #2 Name:** _____

Date of Birth: _____ (Month / Day / Year) Relation to patient: _____

Address (if different from patient): _____

**I have health insurance.**

Great, please provide your card(s) so we can make a copy.

Name of policy holder: _____ Date of Birth: _____ (Month / Day / Year)

Relationship to patient: _____ Insurance Company: _____

Who does your insurance company list as your Primary Care Provider?: _____

**I don't have health insurance.**

No problem! Ask a team member about our Financial Assistance Programs.

Patient's Printed Name: _____

Patient's Date of Birth: _____
Month / Day / Year

## GENERAL CONSENT FOR OUTPATIENT DIAGNOSIS, CARE AND TREATMENT

On an ongoing basis, I request, consent, and authorize Lamprey Health Care, Inc. to perform diagnostic and therapeutic tests and procedures and provide general care and treatment as determined necessary and/or ordered by those health care professionals involved in my care. This includes, but is not limited to, the performance of physical examinations and x-rays or other diagnostic or radiological procedures, as well as the taking of blood, tissues, fluids, or other bodily samples. I also consent and authorize Lamprey Health Care to examine, use for the purposes for which they were provided, store, and dispose of any blood, tissue, fluids, or bodily samples in accordance with legal requirements and customary procedures. I understand I may ask my health care providers about my care, treatment and procedures at any time and I am encouraged to do so.

## BEHAVIORAL HEALTH SERVICES

Lamprey Health Care provides an integrated team approach for the coordination of primary and behavioral health care. As an integrated team all staff members work together, improving communication among providers by sharing information in one medical record and decision making, as well as shared responsibility for a patient's care plan. Behavioral Health Services are available to all individuals. I consent to the sharing of my Private Health Information in order to formulate a plan of care. I understand health care professionals in training may be involved in my care and I consent to their involvement in it under appropriate supervision.

## FINANCIAL RESPONSIBILITY AGREEMENT AND ASSIGNMENT OF BENEFITS

I understand I am financially responsible for all of the charges and bills associated with my care and treatment, except to the extent that all or part of these charges or bills are paid or covered by health insurance, a government health care program (such as Medicare or Medicaid), a financial assistance program, or another party responsible for their payment (all of which are referred to as "Third Party Payers"). I authorize Lamprey Health Care to submit bills or claims and related information concerning my health status, care, treatment, and payments made for my care and treatment to any applicable Third Party Payer and its business associates. I also authorize such Third Party Payers to make direct payments to Lamprey Health Care in response to these bills or claims.

## CONSENT AND AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Lamprey Health Care maintains records in electronic and other forms. These records describe, among other things, my past and current health status, including the diagnosis of any illness and conditions, the nature and results of examinations and tests, treatment provided, and any plans for care or treatment. In addition, these records include billing, social, and other identifying information and may include sensitive information such as genetic testing results, HIV/AIDS status, and drug and alcohol use (all of which is referred to as my "Health Information"). I consent and authorize Lamprey Health Care, when necessary for my treatment, payment of my bills, or Lamprey Health Care's business and healthcare operations, to release and exchange my Health Information with other health care professionals and organizations involved in my care and with business associates that Lamprey Health Care has contracted for the same reasons. I understand that any disclosures of this Health Information may be used or redisclosed by the recipient of the records and will, thus, no longer be protected by federal privacy laws such as 42 CFR Part 2. I understand that my refusal to consent to my records being disclosed for payment purposes may result in Lamprey Health Care refusing to treat me.

**ANY QUESTIONS I HAD ABOUT THIS CONSENT HAVE BEEN ANSWERED. I UNDERSTAND THE INFORMATION IN THIS FORM AND AGREE TO THE CONDITIONS SET FORTH ABOVE. THIS CONSENT SHALL REMAIN EFFECTIVE UNTIL I REVOKE IT IN WRITING, WHICH I MAY DO AT ANY TIME EXCEPT TO THE EXTENT THAT LAMPREY HEALTH CARE OR ANY OTHER RECIPIENT OF INFORMATION DISCLOSED HEREUNDER HAS ALREADY ACTED IN RELIANCE ON IT**

Signed: _____ Date: _____
Month/Day/Year

Relationship of Authorized Representative _____
(For example: Parent, Guardian, or Health Care Agent)

## MEDICARE ONLY

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or by Lamprey Health Care. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

If you have Medicare please sign to confirm you have read and understand this section.

Signed: _____ Date: _____
(Patient or Authorized Representative) Month / Day / Year

# Patient Information Form

**Please Print Clearly**

## If needed, please ask for assistance in completing this form.

*Lamprey Health Care receives state and federal funding to support our services. Occasionally we are asked to report on the general financial status and the race/ethnicity of our patients. Your assistance in completing this information will help us apply for future grant funding.* ***All information is confidential.***

*Thank you for your cooperation.*

**Ethnicity** ☐ Not Hispanic ☐ Mexican ☐ Puerto Rican
☐ Cuban ☐ Another Hispanic, Latino, Spanish origin
☐ Another Hispanic, Latino, Spanish origin combined
☐ Unreported/choose not to disclose

**Are You ... (check all that apply)**
☐ Full Time Student ☐ Part Time Student
☐ Veteran ☐ Migrant Worker
☐ Seasonal Worker

**Race: (Check up to two boxes that best apply.)**

☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Guamanian or Chamorro
☐ Samoan
☐ Black / African American
☐ American Indian/Alaska Native
☐ White
☐ More than one race
☐ Unreported/choose not to disclose

**Sexual Orientation**
What is your sexual orientation?
☐ Straight or Heterosexual
☐ Lesbian, Gay, or Homosexual
☐ Bisexual
☐ Something else
☐ Don't Know
☐ Choose not to disclose

**Gender Identity**
What is your gender identity?
☐ Male
☐ Female
☐ Transgender Male / Trans Male/ Female to Male (FTM)
☐ Transgender Female / Trans Female / Male to Female (MTF)
☐ Genderqueer (neither exclusively male or female)
☐ Additional gender category or Other
☐ Choose not to disclose

| **Communicating With You** | **Yes** | **No** |
|---|---|---|
| Is your primary language English? | ☐ | ☐ |
| If no, what is your primary language? | _____ | |
| Do you need an interpreter? | ☐ | ☐ |
| Are you hearing impaired? | ☐ | ☐ |
| Do you need a sign language interpreter? | ☐ | ☐ |

**Living Arrangements**
☐ Rent ☐ Live with relative or friend
☐ Own Home ☐ Transitional housing
☐ Shelter ☐ Street
☐ Other _____

**How Did You Hear About Us?**
☐ Relative/Friend
☐ Hospital/Other Provider
☐ Internet/Social Media
☐ Community Event
☐ Social Service/Insurance Directory
☐ Other: _____

# Patient Information Form

**Please Print Clearly**

## Mark the income range that applies to your family size.

**Step 1:** Look down the first column and find the row that matches the number of people in your household, including children. If there are more than 8 in your household, use row 8.

**Step 2:** Put a checkmark next to your family size. Then go across the top until you find the income level that best matches your household and check the box above that column.
**CHECK ONLY ONE BOX for family size and ONLY ONE BOX for income.**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Family Size** | **From To** | **From** | **To** | **From** | **To** | **From** | **To** | **Above** |
| ☐ **1** | $0- $15,060 | $15,060.01 | $20,331.00 | $20,331.01 | $27,861.00 | $27,861.01 | $30,120.00 | $30,120.00 |
| ☐ **2** | $0- $20,440 | $20,440.01 | $27,594.00 | $27,594.01 | $37,814.00 | $37,814.01 | $40,880.00 | $40,880.00 |
| ☐ **3** | $0- $25,820 | $25,820.01 | $34,857.00 | $34,857.01 | $47,767.00 | $47,767.01 | $51,640.00 | $51,640.00 |
| ☐ **4** | $0- $31,200 | $31,200.01 | $42,120.00 | $42,120.01 | $57,720.00 | $57,720.01 | $62,400.00 | $62,400.00 |
| ☐ **5** | $0- $36,580 | $36,580.01 | $49,383.00 | $49,383.01 | $67,673.00 | $67,673.01 | $73,160.00 | $73,160.00 |
| ☐ **6** | $0- $41,960 | $41,960.01 | $56,646.00 | $56,646.01 | $77,626.00 | $77,626.01 | $83,920.00 | $83,920.00 |
| ☐ **7** | $0- $47,340 | $47,340.01 | $63,909.00 | $63,909.01 | $87,579.00 | $87,579.01 | $94,680.00 | $94,680.00 |
| ☐ **8+** | $0- $52,720 | $52,720.01 | $71,172.00 | $71,172.01 | $97,532.00 | $97,532.01 | $105,440.00 | $105,440.00 |

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*Thank you for your cooperation.*

Please consider following us!

Updated 10/30/2024

**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.

**********

**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:** _____

**********

**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.**

**********

**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: _____

# Personal Representative Consent

I give permission to Lamprey Health Care to discuss my health information for the purposes of treatment, payment/financial matters, and Lamprey Health Care's operational purposes with:

Personal Representative's Name (print clearly): _____

Relationship to patient: _____ Phone: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Examples of how my information may be used include, but are not limited to, scheduling appointments, requesting refills and/or verbally receiving test results on my behalf. If applicable, the information disclosed may include substance use disorder treatment, behavioral health treatment, and other sensitive health information related to the aforementioned purposes.

This authorization will be valid until I provide Lamprey Health Care with a written notice of cancellation.

Patient's Name Printed Clearly: _____

Patient's Date of Birth: _____ Today's Date: _____

Patient's Signature: _____

Updated 10/30/24

# LAMPREY HEALTH CARE

***Patient Rights and Responsibilities***

**ACCESS**

You have the right to equal access of primary medical care regardless of your race, color, sex, national origin, disability, religion, age, sexual orientation, gender identity, or ability to pay. You are assured access to 24-hour medical assistance and emergency care.

**PRIVACY AND CONFIDENTIALITY**

You have the right to personal privacy and confidentiality except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. You have the right to approve or refuse the release of your medical records to anyone except as required by law or third party contract. Your written consent must be obtained before any record will be released from our files.

**INFORMATION**

You will be fully informed of your medical condition and treatment plan. You have the right to see and examine your medical records, unless medically contraindicated. You are, in turn, responsible for providing complete and accurate pertinent information about your health, lifestyle and/or present illness.

**CONSENT**

Except in emergencies when the patient lacks decision-making capacity and the need for treatment is urgent, you are entitled to the opportunity to discuss and request information related to the specific procedures and/or treatments, the risks involved, the possible length of recuperation, and the medically reasonable alternatives and their accompanying risks and benefits.

**SECURITY**

You have the right to expect that Lamprey Health Care's practices and environment are safe. You are to maintain responsibility for your personal possessions during your visit.

**RESPECT AND DIGNITY**

You will be treated with consideration, respect and full recognition of your dignity, individuality, and cultural and/or spiritual needs, which will include privacy in treatment and in the care of your personal needs. No person will be discriminated against for reason of race, color, sex, national origin, disability, religion, age, sexual orientation, gender identity, or financial status. You, in turn, have the responsibility to show similar respect for our staff and be considerate in communications and in keeping scheduled appointments or notifying the center when unable to keep an appointment.

**INVOLVEMENT IN CARE**

You have the right to participate in developing your plan of care. You have the right to obtain complete and current information regarding your diagnosis, treatment, and prognosis to the degree known by the practitioners responsible for your care.

**COMPLAINTS AND COMMENTS**

You are encouraged to express any concerns, complaints or comments regarding any aspect of your experience with our center. This may be done in person, over the phone or in writing. You are assured that each concern, complaint or comment will be reviewed by the appropriate staff member with timely follow-up with you about the resolution of the issue.

**BILLING INFORMATION**

You have the right to request and receive a fee schedule and information concerning eligibility for third party reimbursement or our sliding fee scale.

**ETHICAL ISSUES INVOLVING CARE**

When conflicts arise in decisions about your care, you, your family and significant others have the right to receive an ethical consultation with appropriate parties, including caregivers, physicians, and others.

**ADVANCE DIRECTIVES**

You have the right to make, review, and modify Advance Directives (Living Will and Durable Power of Attorney) for health care at any time. You have the right to expect that Lamprey Health Care will honor the intent of your directives to the degree allowable by law and Lamprey Health Care policy.

**RESEARCH**

When research activities are approved by the Board of Directors, you have the right to consent or to decline to participate in any proposed study. If you choose to consider participation, the study will be fully explained to you prior to your signing a consent form.

Reviewed 10/30/2024

# Notice of Privacy Practices

*THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.*

## 1. PATIENT PRIVACY

Safeguarding patient privacy is a priority at Lamprey Health Care (LHC). We follow strict federal and state guidelines to maintain the confidentiality of protected health information (PHI). We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices and to abide by the terms of this Notice or other Notice in effect at the time of use of your information.

## 2. HOW DO WE USE YOUR MEDICAL INFORMATION

When you visit Lamprey Health Care, we use your health information to treat you, to obtain payment for services, and to conduct normal business known as health care operations. We do not need your permission to share this information. Examples of how we use your information include:

A. Treatment: We use and disclose PHI to provide treatment and other services to you for example, to diagnose and treat your injury or illness. In addition, we, or one of our Business Associates, may contact you to provide information about treatment alternatives that may interest you. We may disclose PHI to other providers involved in your treatment. We also may use and disclose health information to reach you about appointment reminders and other matters. We may contact you by mail, telephone, or email. We may leave voice messages at the telephone number you give us and we may respond to your email.

B. Payment: We may use and disclose PHI to obtain payment for services that we provide to you. For example, for payment from your health insurer, or other company that pays the cost of your health care.

C. Health Care Operations: We may use and disclose PHI for our health care operations, which include various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our physicians, nurses and other health care workers. We may disclose PHI to our Site Directors, Chief Medical Officer, and/or Chief of Clinical Services in order to resolve any complaints.

## 3. BUSINESS ASSOCIATES

We may sometimes disclose PHI to organizations or individuals that assist us in performing some Health Care Operations. For example, we have a business associate contract with our record storage company and for shredding services. Our agreements with these “Business Associates” provide for continued privacy protection of that protected health information.

## 4. INFORMATION WE MAY SHARE WITHOUT YOUR WRITTEN PERMISSION

On a limited basis we are permitted or required to disclose health information without your written permission. These situations are described below:

A. Disclosure to Relatives, Close Friends and Other Caregivers: We may use or disclose certain relevant PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure. If you object to such uses or disclosures, please notify the Medical Team or Provider. If you are not present, you are incapacitated, or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interest. If we disclose information, we would disclose only information that is directly relevant to the person’s involvement with your health care or payment related to your health care. We may also disclose PHI in order to notify (or assist in notifying) such persons of your location, general condition or death. If you object to such uses or disclosures please notify the Privacy Officer.

B. Public Health Activities: We may disclose PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration, (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work- related illnesses and injuries or workplace medical surveillance.
C. Victims of Abuse, Neglect or Domestic Violence: If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.
D. Health Oversight Activities: We may disclose PHI to government oversight agencies for activities as authorized by law, including, for example, audits, investigations, inspections and licensure.
E. Judicial and Administrative Proceedings: We may disclose PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.
F. Law Enforcement Officials: We may disclose PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.
G. Decedents: We may disclose PHI to a coroner or medical examiner or funeral director as authorized by law.
H. Organ and Tissue Procurement: We may disclose PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.
I. Research: We may use or disclose PHI without your consent or authorization if an Institutional Review Board/ Privacy Board approves a waiver of authorization for disclosure.
J. Health or Safety: We may use or disclose PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.
K. Specialized Government Functions: We may use or disclose PHI to units of the government with special functions, such as the U.S. Military or the U.S. Department of State , to National Security and Intelligence Agencies and for protective services for the President and others.
L. Worker's Compensation: We may disclose PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.
M. As Required By Law: We may use and disclose PHI when required to do so by any other law not already referred to in the preceding categories.
N. Fundraising:We may contact you for fundraising purposes, however you have the right to opt out of receiving these types of communications.

## 5. USE AND DISCLOSURES REQUIRING YOUR WRITTEN PERMISSION

A. Use or Disclosure with Your Authorization For any purpose other than the ones described in Section 4, we will only use or disclose your PHI when you give us your written permission. Release of PHI for marketing purposes and the sale of PHI requires your written permission.
B. Uses and Disclosures of Your Highly Confidential Information: Federal and State law require special consent for disclosure of certain sensitive information about you including: Drug and alcohol abuse treatment, Psychiatry treatment, HIV/AIDS testing, Sexually Transmitted Disease testing, and Genetic testing.

## 6. YOUR HEALTH INFORMATION RIGHTS

A. Right to Request Restrictions: You have the right to ask that we limit how we use or disclose your PHI. You may also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. We are required to agree to your request only if: (1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), and (2) your information pertains solely to health care services for which you have paid in full. For other requests we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment.

B. Right to Receive Confidential Communications: You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right to Inspect and Copy Your Health Information: You may request access to your medical and billing records maintained by us in order to inspect and request copies of the records, including in an electronic format. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you desire access to your records, please obtain a record request form. Allow 30 days for record requests and 60 days for a record amendment. If you request copies, a fee may apply as allowed by New Hampshire RSA 332-I:1 Medical Records.

D. Right to Revoke Your Authorization: You may revoke Your Authorization, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Privacy Officer.

E. Right to Amend Your Records: You have the right to request that we amend PHI maintained in your medical and billing records. If you desire to amend your records, please obtain an amendment request form from the Medical Records Department. All requests for amendments must be in writing. We will review your request to amend your PHI and respond within 60 days.

F. Right to Receive an Accounting of Disclosures: Upon written request, you may obtain an accounting of certain disclosures of PHI for the preceding six years.

G. Right to Receive Paper Copy of this Notice: Upon written request, you may obtain a paper copy of this Notice, even if you agreed to receive such notice electronically.

H. Right to Breach Notification: We are required by Federal Law to notify you of a breach of your PHI. This notification will be sent to you in writing and describe the details of the breach. This notice will also contain contact information so that you may ask questions about the breach.

## 7. FURTHER INFORMATION: COMPLAINTS

If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact our Privacy Officer. You may also send a written complaint to the US Department of Health and Human Services. The Privacy Officer can supply you with the address upon request. We will not discriminate against you for filing a complaint.

**EFFECTIVE DATE**

This notice is effective on April 14, 2003.
Updated September 2013.
Updated June 28, 2016.
Updated July 10, 2019.
Updated November 27, 2024


**8. RIGHT TO CHANGE TERMS OF THIS NOTICE**

We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in waiting areas of the Practice and on our website at https://www.lampreyhealth.org You may also obtain any revised notices by contacting the Privacy Officer

**PRIVACY OFFICER**

You may contact the Privacy Officer at:
207 South Main Street
Newmarket, NH 03857
Tel (603) 244-7307

A copy of this Notice of Privacy Practices is located at https://www.lampreyhealth.org under the section titled Patient Resources - Health Center Policie


# Acknowledgement of Notice of Privacy Practices

**Acknowledgement**
I acknowledge that I have been offered the opportunity to review and receive a copy of the Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

**Consent And Authorization**
I do hereby consent and authorize Lamprey Health Care to release all information contained in my financial, medical, and contact records, including diagnoses and test results, to my insurance company or health plan, their agents and independent contractors, to third party business associates that supply goods or services to this office, where such goods/services require access to such information, or to any other person or entity that is responsible for paying or processing payment, of any portion of my bill, for the purposes of administration, billing and quality and risk management. This consent applies to all records created in the course of and relating to my treatment and for the purpose of reimbursement for treatment.

**Right To Terminate Or Revoke Authorization**
- I understand I have the right to revoke this authorization in writing at any time.
- I understand the revocation will NOT apply to information that has already been released.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that this authorization will expire in one year from today.
- I may request to inspect or copy any information used or disclosed under this agreement.

**Acceptance Of Privacy Practices**
Initial Here*. _____
I have read the above and authorize the disclosure of the protected health information as stated.

Your relationship to the Patient?