LAMPREY HEALTH CARE AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH MEDICAL RECORD INFORMATION

207 South Main St. Newmarket, NH 03857 Ph# (603) 659-3106 Fax# (603) 659-8003

PATIENT INFORMATION:

Patient Name (***Please Print***) _____ DOB____/_____/_____

Patient Address_____ Phone #_____

City State Zip

Please check one below:

☐ **SEND TO** ☐ **PICK UP** ☐ **VERBAL** ☐ **SEND RECORDS THRU LHC PORTAL**_____

I HEREBY AUTHORIZE LAMPREY HEALTHCARE TO RELEASE MY INFORMATION TO:

Name of Person or Organization_____Phone#_____ Fax#_____

Address_____

City State Zip

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

_____ Abstract of last 3 years or most recent to include: Chart summary, Office notes, Immunizations, Imaging, Labs, Hospital reports, Consult notes, Pathology and GYN records. *** If more than 3 years old**: Colonoscopy, Cardiac reports, PSA, Pap and Mammogram will be released.

_____ Physical and immunizations Other **(*Please specify*)** _____

For the Purpose of: ☐ **Trans of Care** ☐ **Attorney** ☐ **Insurance** ☐ **Personal** ☐ **Other:**_____

***If Transferring please give reason:** _____

I understand that the information I have agreed to release may include but is not limited to SENSITIVE information: the following types of information will be released UNLESS you *initial* in the space provided:

_____ **Alcohol/drug abuse treatment records**
_____ **Behavioral health treatment records**
_____ **Child abuse/neglect records**
_____ **Counseling/ family problems**
_____ **Genetic testing**
_____ **HIV/AIDS test results**
_____ **Sexual assault/abuse**
_____ **Sexual preference**
_____ **Sexually transmitted**
_____ **Termination of pregnancy**

- Consent for 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 above 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.
- This authorization will expire in one year (365) days from the date below or on: ____/_____/_____
- A copy of this release is as valid as an original (e.g. fax).

"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/Authorized Representative Relationship if not patient

I.D. checked at front desk when info is picked up ***(Please Initial)*** _____

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.

DATE: _____ Interpreter's Signature:_____