

LAMPREY HEALTH CARE

Where Excellence and Caring go Hand in Hand

Authorization to Disclose Protected Medical Record Health Information

Patient Information:

Patient Full Name (*please print*)

Previous Name if applicable

Street Address

Date of Birth

City State Zip Code

Daytime Phone #

Receive Medical Records from:

_____ Doctor/Organization		_____ Phone #	_____ Fax #
_____ Street Address	_____ City	_____ State	_____ Zip Code

Information to be released:

____ Abstract of **last 3 years of treatment on file** or most recent to include: Chart Summary, Advanced Directives, Immunizations, Progress Notes, Imaging, Labs, Hospital Reports, Consultation Notes, Pathology, GYN Records, PSA, Urology, and Dermatology. Colonoscopy, Cardiac Reports, Pap and Mammogram if more than 3 years old.

____ Only some portion of the record (*please specify what to release*) _____

Records to be sent to the office below: Please Check One:

LHC-Nashua Center

Attn: Medical Records
22 Prospect Street
Nashua, NH 03060
P: (603) 883-1626
F: (603) 881-9914

LHC-Newmarket Center

Attn: Medical Records
207 So. Main Street
Newmarket, NH 03857
P: (603) 659-3106
F: (603) 659-8003

LHC-Raymond Center

Attn: Medical Records
128 State Route 27
Raymond, NH 03077
P: (603) 895-3351
F: (603) 895-0773

Reason for release of records:

____ Permanent Transfer Other (*please specify*) _____

This authorization is valid for one year from date of signature and may be revoked by writing to the Organization listed above. My record may contain sensitive information (Alcohol and or drug use, STD, HIV/ AIDS, Genetic Testing, Mental and Behavioral Health) and I agree to this release. I have the right to receive a copy of this authorization. Records released pursuant to this authorization may be re-released and no longer protected by Federal Privacy Laws. Consent for release of information is not required as a condition of treatment.

This information is 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.

Please print name of Patient or Authorized Representative

Relationship if not Patient

Signature of Patient/Authorized Representative

Date