EverCare Medical Associates

59 Stiles Road, Salem, New Hampshire 03079
Phone: (603) 685-4609 Fax: (603) 824-6857

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEDGED HEALTH INFORMATION

A. PATIENT INFORMATION

PATIENT NAME: _____ PATIENT DATE OF BIRTH: _____

PATIENT MEDICAL RECORD # _____

PATIENT ADDRESS: STREET: _____APT#: _____

CITY: _____STATE: _____ ZIP: _____

PHONE NUMBER: _____

B. PERMISSION TO SHARE: I give my permission to share my protected health information.

From:	To:
Name:	Name:
Address:	Address: _____
Telephone Number:	Telephone Number: _____
	Fax Number:
Send by:	Purpose (check the appropriate box)
D Mail	D Medical Care D Other (please specify)*
	D Insurance* _____
D Electronically (secure email)	D Legal Matter* _____
Email Address:	D Personal*
	D School * Copying fees may apply

C. INFORMATION TO BE RELEASED (Please check all that apply, and specify dates):

O Medical Record Abstract/dates _____ _
(e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)

O Clinic Visit Notes/dates _____ _

O Discharge Summary _____ _

O Lab Reports _

O Operative Reports _____ _

O Pathology Reports _____ _

O Radiation Reports

O Radiology Reports

O Photographs/dates (costs may apply) _____

O Billing Records/dates _____ _

O Other *(please specify below and include dates)* ____

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D. Please check YES to indicate if you give permission to release the following information if present in your record:

O Yes **HIV test results** (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
SPECIFY DATES _____

O Yes **Genetic Screening test results (SPECIFY TYPE OF TEST)** _____

O Yes **Alcohol and Drug Abuse Records** Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon oral or written request.

O Yes **Other(s):** Please List _____

O Yes Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) *(I understand that* my *permission may not be required to release* my *mental health records for payment purposes)*

O Yes Confidential Communications with a Licensed Social Worker

O Yes Details of Domestic Violence Victims' Counseling

O Yes Details of Sexual Assault Counseling

E. I understand and agree that:

* EverCare Medical Associates cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality may or may not protect this information once it has been released to the recipient.

* This authorization is voluntary.

* My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form.

* I may cancel this authorization at any time by submitting a written request to the Department or Office where I originally submitted it, except:

* If EverCare Medical Associates has already relied upon it (for example, once information is released, it will not be retrieved)

* If I signed this authorization as a condition of obtaining insurance, other laws may provide the insurer with a right to contest a claim under the policy or the policy itself.

This authorization will automatically expire **6 months from the date signed** unless otherwise specified:

My questions about this authorization form have been answered

>- **Patient's Signature:** _____

>- **Print Name:** _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: _____

Print Name: _____ **Date:** _____