Authorization Form for Use and Disclosure of Protected Medical Information

Pelham Healthcare Associates
49 Atwood Road Suite #1
Pelham, NH 03076
Phone: 603-635-2802
Fax: 603-635-3070

Patients Name: ____
Last First Middle

Address: ____

Date of Birth: ______________ Phone: ________________

I hereby authorize Pelham Healthcare Associates to RELEASE or OBTAIN (Please check one)

Recipient Person/Office: ____

Address: ____

My protected health information including copies of my medical records to/from the person or class of persons listed above.

****If you are obtaining your records from your previous provider please forward this form to that provider and have them mail the records to the address above****

INFORMATION TO BE OBTAINED: (Check all that apply)

- o Complete medical records
- o Lab results
- o Radiology results
- o History & Physical
- o Immunization Records
- o Clinical Visit Notes
- o Other (please specify) ________________________

TERM: This authorization will remain in effect until (please check one)

- o From the date of this authorization until the day of _____20
- o Until one year from the date signed

PURPOSE: I authorize Pelham Healthcare Associates to use and disclose my health information during the term of this authorization for the following specific reasons:

- o Transferring out of Practice
- o Continuing medical care
- o Insurance/disability
- o Personal use'
- o Attorney/Legal case

I understand that I may inspect or obtain a copy of the protected health information described by this authorization. I understand that information used or disclosed pursuant to this authorization could be specific to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Requests for access to and copies of your medical information must be submitted to Pelham Healthcare Associates by completing and signing this form.

The fee for the release of medical records is as follows: (please choose one)

- o Records on a CD: $45.00 (Please note not all practices accept CD)
- o Paper Records: $0.50 per page

Please be sure payment is made with this request.

I have read and understand the terms of this authorization and I have had the opportunity to ask questions about the use and disclosure of health information. By signing my name below, I hereby, knowingly and voluntarily authorize Pelham Healthcare Associates to disclose my protected healthcare information in the manner as described above. I also agree and acknowledge the fee for processing and distribution of the medical records.

____________________________________ ____________

Signature of Patient Date

If the patient is a minor or is otherwise unable to sign this authorization, the signature of a parent, guardian, or legal representative is required.

____________________________________ _____________

Signature of Personal Representative Date

____________________________________ ____________________

Print Name Relationship to Patient

Please fill out the survey in the attached link. Your input to improve our practice is greatly appreciated. Visit our website at:

http://www.pelhamhealthcareassociates.com/patient-satisfaction-survey.html