Authorization Form for Use and Disclosure of Protected Health Information

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

Patient's 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 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 DISCLOSED: (Check all that apply)

o Complete medical record 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 (1) from the date signed

Purpose: I authorize Pelham Healthcare to use and disclose my health information during the term of this Authorization for the following specific reason:
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 subject 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: $ 35.00 (please note not all practices will accept CD)
o Paper records: .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 to use and disclose my Personal Health Information in the manner as described above. I also agree and acknowledge the fee for the 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.
http://www.pelhamhealthcareassociates.com/patient-satisfaction-survey.html