Alice Peck Day Memorial Hospital

Authorization For Disclosure of Protected Health Information

Name:
MR#: place patient sticker here
DOB:

Name:_____ DOB:_____ MRN:_____

I authorize Alice Peck Day Memorial Hospital and clinics to disclose my protected health information for the following purpose:

_____

I understand this information may include treatment for drug/alcohol abuse, mental illness, HIV status, or genetic testing records. I specifically authorize the release of this information (if applicable):

☐Yes ☐No Initials:_____

Name of person(s) or entity to receive information:_____

_____

Street Address City State Zip Code Phone Number

INFORMATION TO BE DISCLOSED:

From: ☐***Hospital***

☐***Clinic (specify):*** ☐Community Care ☐Women's Care ☐Orthopaedic Clinic
☐Surgical Clinic ☐Sleep Center ☐Occupational Health
☐Podiatry Clinic ☐Pain Clinic ☐Hand Clinic

Information Needed: ☐History & Physical ☐Discharge Summary
☐Emergency Report ☐Operative Report ☐Consultation
☐Physician Orders ☐Diagnostic Tests ☐Progress Notes
☐Rehab Records ☐Medication List ☐Office Notes
☐Vaccinations/Immunizations
☐Work/School Note/Release
☐Abstract: A Collection of Documents Specific to Date

☐**VERBAL DISCLOSURE ONLY AS IT PERTAINS TO CURRENT CARE AND TREATMENT**

Other:_____

Dates of care to be released: From:_____ To:_____

I understand that:

- I may refuse to sign this authorization and my healthcare and payment of my healthcare will not be effected based upon refusal to sign the authorization.
- I may revoke this authorization at any time by delivering to APD at 10 Alice Peck Day Drive, Lebanon, NH 03766 a written note. I understand that the revocation will not apply to records that have been disclosed prior to receipt of the written revocation.
- If I authorize disclosure of my protected health information, and the recipient is not a covered entity, the recipient may further disclose this information and federal law will no longer protect it.
- I have the right to inspect of copy the information that I am consenting to release within the established policies of Alice Peck Day Memorial Hospital.

This authorization will expire one year from the date this document is signed unless I otherwise specify an alternative date or event described here:_____

_____ _____ _____
Signature of Patient/Personal Representative Phone Number Date

_____ _____
Printed Name of Personal Representative Legal Authority of Personal Representative

We will provide you a copy of this authorization at your request.

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