DMC Primary Care
ATTN: Health Information
14B Tsienneto Road
Derry, NH 03038
Phone: (603) 537-1300 Fax: (603) 537-1355

AUTHORIZATION TO USE /DISCLOSE HEALTH INFORMATION

Patient's Name: _____
Last First Middle

Address: _____

Date of Birth: _____ **Preferred Phone:** _____

***I hereby authorize DMC Primary Care to RELEASE TO ☐ or RECEIVE FROM ☐ (please check one)**

FACILITY: _____ **PROVIDER:** _____

ADDRESS: _____

FAX: _____ **PHONE:** _____

INFORMATION TO BE DISCLOSED: Please select one

☐ **Chart Abstract (last 3 years of treatment- including all immunizations, colonoscopies, pap smears, mammograms)**

☐ **Specific Documents: Immunizations ☐ Physicals ☐ Recent Labs ☐_____ Imaging ☐_____**

☐ **Verbal Exchange Complete Chart ☐**

Additional Notes/Other:_____

*****IMPORTANT PLEASE READ PARAGRAPH BELOW*****

MY HIGHLY CONFIDENTIAL INFORMATION: By signing my initials next to a category of highly confidential information listed below, **I DO NOT** authorize the use and/or disclosure of the type of highly confidential information indicated next to my initials, otherwise, the information listed below may be sent/obtained as requested.

☐ Mental Health and Behavioral Health Treatment _____
☐ HIV/AIDS Testing and/or Treatment _____
☐ Sexually Transmitted Disease _____
☐ Substance Abuse (e.g.: alcohol and/or drugs) _____
☐ Genetic Testing _____

PURPOSE: Please select one

☐ Transferring Out of Practice:(Reason)_____
☐ Medical Care/ Coordination of care
☐ Disability Determination
☐ Attorney/ Legal Case
☐ Personal copy
☐ Other: _____

Requests for access to and copies of your medical information must be submitted to Derry Medical Center by completing and signing this form.

- I understand that I may inspect or obtain a copy of the protected health information described by this authorization. I understand that Derry Medical Center will not condition treatment, payment or (if applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure and that I may refuse to sign this authorization.
- I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of DMC Primary Care/Derry Medical Center. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
- I understand that I have a right to receive or copy 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.

❖ If you're requesting complete records for personal use or transferring out of the practice, the 1st copy released is FREE. **For additional copies, the practice charges a flat fee of $15.00.** Exception: Third party requests will be subject to regulated copy fees as outlined by HIPAA.

Expiration Date: Authorization to Disclose Health Information is valid one-year from date of signature below.

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 DMC Primary Care to use and disclose my PHI in the manner described above:

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Name **Description of Personal Representative's Authority**