Foundation Medical Partners
southern new hampshire health

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FOUNDATION MEDICAL PARTNERS

Patient Name: _____ Date of Birth: _____

Address: _____

I authorize *(Practice Name)* _____

to use, disclose or release my protected health information (medical records) described below to:

_____

Name of person or entity

_____

Address, City, State, Zip Code

For the following purpose: (at patient's request is sufficient):_____

Dates of service requested: _____

If my initials appear below, I request that you do <u>NOT</u> send the following records:

_____, I <u>do not</u> authorize release of any records concerning drug or alcohol treatment and/or psychiatric treatment.

_____, I <u>do not</u> authorize the release of any records concerning genetic testing for the purposes set forth above.

_____, I <u>do not</u> authorize release of any records concerning my diagnosis of or treatment for HIV, AIDS or ARC, or contain some other reference to my identity as an HIV, AIDS or ARC patient for the purpose set forth above.

I understand that I may inspect or copy the protected health information described in this authorization.

I understand that this authorization may be revoked in writing and delivered to the Foundation Medical Partners location of care at any time, and that Foundation Medical Partners must cease using this authorization, except that Foundation Medical Partners may complete any actions it initiated in reliance on this authorization and prior to my revocation

I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I understand that Foundation Medical Partners shall not condition treatment, payment or enrollment in the health plan or eligibility for benefits on my providing authorization for the requested used or disclosure and that I may refuse to sign this authorization.

I understand that by authorizing this release of my medical records I also release Foundation Medical Partners from all legal responsibility or liability that may arise from the release of these medical records.

DATE _____
(Required)

_____
Signature of patient or representation

_____
Authority of representative (parent of minor, guardian, etc)
Copies may be attached of documentation

EXPIRATION: This authorization will expire on (date or event):_____. If no date or event is specified, the authorization shall expire six months from the date it was signed.