Valley Regional Hospital

243 Elm Street, Claremont, NH 03743
603-542-7771
Integrity | Excellence | Accountability | Compassion

Information to be mailed to (check one):

___Valley Regional Primary Care Phys.
17 Main Street, Newport NH 03773

___Associates in Medicine
241 Elm Street, Claremont NH 03743

___Valley Family Physicians
5 Dunning Street, Claremont NH 03743

___Valley Regional Hospital
243 Elm Street, Claremont NH 03743

___Connecticut Valley Home Care
958 John Stark Hwy. Newport NH 03773

___Valley Regional Urology
243 Elm Street, Claremont NH 03743

___Valley Regional Surgical Associates
243 Elm Street, Claremont NH 03743

___Valley Regional Orthopaedics
241 Elm Street, Claremont NH 03743

___Valley Primary Care
Family Med & Pediatrics
7 Dunning Street, Claremont NH 03743

☐ **Other:** _____

REQUEST FOR USE AND/OR DISCLOSURE BY OTHERS

Protected Health Information Release Authorization

Full Name:_____ Date of Birth:_____ Daytime phone#:_____

This will Authorize _____ to (USE, DISCLOSE, OR OBTAIN) my protected Health information to/from _____ as described below for the following purpose:

o **Family Education** o **Continuity of Care** o **Facilitate OPD Treatment** o **Legal** o **Other:** _____

_____ Discharge Summary (Date) _____
_____ History & Physical Exam (Date) _____
_____ Operative Note (Date) _____
_____ Consultation (Date) _____
_____ Progress Notes (Date) _____
_____ X-ray, Scans, Etc. (Date) _____
_____ Laboratory Data (Date) _____
_____ Emergency Room Records (Date) _____
_____ EKGs (Date) _____
_____ Nurse's Notes (Date) _____
_____ Other: _____

Dates of care included: _____ to _____

The information authorized for disclosure may include: (INITIAL all lines beside the information that you want TO BE RELEASED and/or write NO on the lines beside the information that you DO NOT want to be released.)

_____Mental Health Treatment _____ HIV/AIDS related illness _____Sexually transmitted disease
_____Genetic Testing _____ Drug or alcohol treatment _____ Hepatitis Status

- I understand that information may be released via FAX machine, unless otherwise specified.
- I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
- I understand that the Valley Regional Healthcare shall not condition treatment, payment or 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 this authorization may be revoked in writing and delivered to the _____ Department of Valley Regional Healthcare at any time, although 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 information used or disclosed as a result of this authorization could be re-disclosed by the receiver and, if so, may not be subject to federal or state law protecting its confidentiality.
- I understand that Valley Regional Healthcare shall have the opportunity to obtain reimbursement for copying costs as set in state statute. $ 15.00 for first 30 pgs. $.50 per page from (third party or patient) as a result of this authorization. (The details of the state statute are available upon request.)

Total costs for requested copies: $_____ ☐ I am unable to pay for these requested copies.

_____ _____/_____
Date Signature of individual or representative/ **Print name signed**

_____/_____ _____
Witness Print Name Signed (Authority of relationship of representative)

EXPIRATION DATE: This authorization will expire on (date no later than one year from now) _____.
(If no date is stated, this authorization expires six months from the date it was signed.)

COPY PROVIDED: The Valley Regional Healthcare will provide a copy of this authorization, when signed to the subject individual. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.

Form #4844/7680.006 Release of Information **Reviewed: 9/2004, 9/2005, 10/2006, 10/2007, 4/08, 10/08** **Revised 8/2003, 10-2007, 4/08, 10/08, 2/09, 1/11, 3/13, 1/15, 11/16**