

**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

 **Associates in Medicine Pediatrics**  
9 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 03743

 **Valley Regional Surgical Associates**  
243 Elm Street Claremont NH 03743

 **Valley Regional Orthopaedics**  
241 Elm Street Claremont NH 03743

 **Valley Primary Care**  
7 Dunning Street, Claremont 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:

<input type="checkbox"/> <b>Family Education</b>	<input type="checkbox"/> <b>Continuity of Care</b>	<input type="checkbox"/> <b>Facilitate OPD Treatment</b>	<input type="checkbox"/> <b>Legal</b>	<input type="checkbox"/> <b>Other:</b> _____
_____ Discharge Summary (Date) _____	_____ Laboratory Data (Date) _____			
_____ History & Physical Exam (Date) _____	_____ Emergency Room Records (Date) _____			
_____ Operative Note (Date) _____	_____ EKGs (Date) _____			
_____ Consultation (Date) _____	_____ Nurse's Notes (Date) _____			
_____ Progress Notes (Date) _____	_____ Other: _____			
_____ X-ray, Scans, Etc. (Date) _____				

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.