Valley Regional Hospital

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

Information to be mailed to (circle one):

Valley Regional Hospital
243 Elm Street, Claremont NH 03743

Health Information/Medical Records
ph: 603-542-1831 f: 603-542-1815

Valley Regional Emergency Department
Fax: 603-542-1153 Ph: 603-542-1822

****All Release of Information requests for the practices below will be processed by Health Information/Medical Records (fax and phone above)****

Associates in Medicine
241 Elm Street, Claremont NH 03743

Valley Family Physicians
5 Dunning Street, Claremont NH 03743

Valley Primary Care
7 Dunning St, Claremont, NH 03743

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

Women's Health
243 Elm Street, Claremont NH 03743

Other: _____

REQUEST FOR USE AND/OR DISCLOSURE BY OTHERS
Protected Health Information Release Authorization

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

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 _____
(**If no dates will default to last 3 years. Do **not** request "first to last" unless pediatric patient)

The information authorized for disclosure may include: (**INITIAL all lines beside the information that you want TO BE RELEASED**)

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

Route of delivery (please circle): Paper copies Fax (provider/hospitals only) CD Secure Email

- 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.

_____ _____/_____
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.)