Dartmouth Health

Valley Regional Hospital
243 Elm Street, Claremont, NH 03743

REQUEST FOR USE AND/OR DISCLOSURE OF Protected Health Information Authorization Form

Authorization is also valid for the following Valley Regional Hospital departments:		
Associates In Medicine	Valley Primary Care	Valley Regional Urology
Valley Regional Surgical Associates	Valley Regional Orthopedics	Women's Health
Valley Regional Urgent Care	Valley Regional Emergency Room	

Patient Information:

Full legal name:	DOB:
Phone number:	Email:

I authorize the use and disclosure of my protected health information as indicated below. The purposed of this disclosure is for the following reason(s) **(please initial):** ___Further Medical Care ___Personal Use ___Legal ___Insurance ___ School ___Transfer of Care ___Other:_____

The Information is to be disclosed/released by:	**The Information is to be released/sent to:**
Name:	Name:
Address:	Address:
City & State:	City & State:
Zip:	Zip:
Phone**:** **Fax:**	Phone**:** **Fax:**
Email:	Email:

By **initialing** the spaces below, I authorize the release of the following records, if such records exist:

	Discharge Summary		History and Physical		Operative/procedure note
	Consultations		Progress notes		Emergency Dept Records
	Labs, Xrays, EKGs, etc.		Outpatient Clinic Notes		
	Other:				

Dates of treatment: _____ Last 3 years (please initial) Specific Dates: From: _____ To: _____

Additionally, the information disclosed may include the following and I authorize such disclosure (Please initial):

	Mental Health Treatment		HIV/AIDS related illness		Drug/Alcohol Treatment***
	Sexually Transmitted disease		Hepatitis Status		Genetic Testing
	Psychotherapy Notes	***Further disclosure prohibited or governed by 42 CFR Part 2			

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 Hospital 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 Hospital 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.)