Derry Medical Center

RELEASE OF HEALTHCARE INFORMATION

PATIENT IDENTIFICATION

NAME: _____ DATE of BIRTH: _____

ADDRESS: _____ ZIP _____ PHONE: _____

My Primary Care Physician (PCP) is: ☐ Dr. Bennett ☐ Dr. Fitzgerald ☐ Dr. Rosenbaum

AUTHORIZATION TO:

☑ **Release Patient Information To**: Derry Medical Center
Address: 6 Tsienneto Road, Derry, NH 03038

☑ **Released From**: Elliot Physician Network (EPN), Elliot Professional Services (EPS), and Elliot Hospital
Address: One Elliot Way, Manchester NH 03103

PATIENT INFORMATION TO BE RELEASED: (Check all that apply)

☐ Complete Medical Record	☑ Most recent H & P	☑ Other: **See Below:**
☐ All Consult Reports	☐ Complete Medication list	Patient Clinical Summary
☐ X -Ray	☐ Discharge Summary	Most Recent Complete Physical
☑ Lab – Last 12 months	☐ Last 2 Progress Notes	

DATES OF SERVICE TO BE RELEASED: From: January 1, 2015 To: December 31, 2016

INFORMATION TO BE: ☐ Picked Up ☐ Electronic – CD
☑ Mailed ☐ Electronic – Flash Drive
☐ Faxed (see fax release notice below) –

*Fax Release Notice. I am aware that the above requested information is to be released via a fax machine. I am also aware of the risks associated with faxing protected health information, and *sensitive information, including but not limited to: erroneous transmission, lack of confidentiality safeguards at the site of the receiving machine and incomplete transmission information.

PURPOSE for which this information is being released: (check one)

☑ Continued Medical Care	☐ Legal	☐ Permanent Transfer to Another Provider
☐ Insurance	☐ Personal	☐ Consultation with Specialist
☐ Other		

I UNDERSTAND THAT:

The information released is confidential and must be used for the purpose that it was requested for; however, once this information is disclosed, the information may be subject to re-disclosure and may no longer be protected by federal and state confidentiality laws. I may revoke this authorization at any time in writing, provided the information has not already been disclosed in reliance on this authorization.

I know that this authorization is voluntary, and I may refuse to sign this form. I hereby authorize the release of my patient information stated above and release Derry Medical Center from any legal responsibility or liability relating to the release of information. This authorization is considered valid for a period of one year from the date of signature or until (date) December 31, 2017

_____

Patient/Parent/Legal Agent Signature Date