DERRY MEDICAL CENTER

Medical Release Form
For Use and Disclosure of Protected Health Information

Derry Medical Center
Attn: Medical Records Department
6 Tsienneto Road, Suite 100
Derry, NH 03038
603-537-1300

Patients Name: _____
Last First Middle

Address: _____

Date of Birth: _____ **Preferred Phone:** _____

I hereby authorize **Derry Medical Center** to **RELEASE TO** ☐ or **RECEIVE FROM** ☐ (please check one)

FACILITY: _____

ADDRESS: _____

Reason for releasing my records, other than transferring out of the practice:

_____

My Protected Health Information, includes copies of my medical records to/from the person or class of persons listed above:

INFORMATION TO BE DISCLOSED: (Check all that apply): Put Dates if needed otherwise please consider it to be "ALL"

- ☐ All
- ☐ Office Notes w/in past 24-months only
- ☐ Radiology Results Date: _____
- ☐ Immunization Records (All)
- ☐ Surgical Reports (please specify): _____
- ☐ Lab Results-Date: _____
- ☐ Hospital Records-Date: _____
- ☐ Cardiac Testing -Date: _____
- ☐ Clinical Summary Only

Additional Notes/Other:_____

MY HIGHLY CONFIDENTIAL INFORMATION:

By signing my initials next to a category of highly confidential information listed below, I DO NOT authorize the use and/or disclosure of the type of highly confidential information indicated next to my initials, otherwise, the information listed below may be sent/obtained as requested.

- ☐ Information about a Mental Illness or Developmental Disability: _____
- ☐ Information about HIV/AIDS Testing and/or Treatment: _____
- ☐ Information about Sexually Transmitted Disease: _____

☐ Information about Substance Abuse (e.g.: alcohol and/or drugs): _____
☐ Information about Child Abuse and/or Neglect: _____
☐ Information about Genetic Testing: _____

TERM: This Authorization will remain in effect (please check one):

☐ From the date of this Authorization until (date) _____.
☐ Until One Year (1) from the date signed.

PURPOSE: I authorize **Derry Medical Center** to use and disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s):

☐ Transferring Out of Practice
☐ Continuing Medical Care
☐ Insurance / Disability
☐ Personal Use
☐ Attorney / Legal Case

Requests for access to and copies of your medical information must be submitted to Derry Medical Center by completing and signing this form.

- I understand that I may inspect or obtain a copy of the protected health information described by this authorization. I understand that Derry Medical Center will not condition treatment, payment or (if applicable) 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 I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of Derry Medical Center. I also understand that such 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 pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- I understand that once Derry Medical Center receives my health records from any previous provider, only the following pertinent medical information from those obtained records will be extracted and scanned into my Derry Medical Center electronic medical record: mammogram results, last physical, cardiology testing, recent lab results (including sensitive labs), electrocardiograms, recent consult notes, immunizations, chart summaries, oncology notes, spine MRI, hospital discharge notes. Unless otherwise indicated below, all other information will be shredded by an authorized HIPAA compliant vendor. It is not the responsibility of Derry Medical to maintain or store all previous medical records from other provider practices.
- ❖ **If you choose to have Derry Medical return the previous records to you, please check here ☐. You will receive a call once your records are ready for pick up. You will be required to pick up the records from the office at which you are normally seen within 14 days of our call, otherwise the records will be shredded as stated above.**

❖ If you're transferring out of our practice, the 1st Copy released is FREE. **For additional copies the practice charges a $15.00 for the first 30 pages and .50 for each additional page. The fee for any records to be copied from an outside facility will be 50 cents per page.** ❖

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of health information. By signing my name below, I hereby, knowingly and voluntarily authorize Derry Medical Center to use and disclose my PHI in the manner described above:

_____ _____
Signature of Patient **Date**

COPY PROVIDED: Derry Medical Center shall provide a copy of this signed authorization to the patient if you request. 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. New Hampshire state law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions.

REV 03/26/2019 DLD