

DOVER WOMEN'S HEALTH
700 CENTRAL AVE.
DOVER, NH 03820
603-742-2424
FAX 603-742-1763

Protected Health Information Release Authorization

Name _____ Date of Birth _____

This release will authorize Dover Women's Health

(initial)

To release my protected health information to:

To receive my protected health information from:

Name of Practice or Person:

Name

Address

Phone

Fax

Check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Cardiology Records | <input type="checkbox"/> Medication Records |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Neuroscience Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Office Notes |
| <input type="checkbox"/> EKG | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Emergency Room Records | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Rehab Services |
| <input type="checkbox"/> Other: (Specify) _____ | |

Dates of care: From: _____ To: _____

The information authorized for disclosure may relate to:

Initial all that apply. Without specific authorization none of this information will be disclosed
_____ Mental Illness (excluding Psychotherapy notes) _____ HIV Related Illness
_____ Drug and/or Alcohol treatment* _____ AIDS

*Federal Confidentiality Law-42 CFR part 2, prohibits re-disclosure unless expressly permitted in writing by the patient or as otherwise permitted by 42 CFR Part 2.

- I understand that I may refuse to sign this authorization. Dover Women's Health will not refuse to treat me based on my refusal to sign the authorization, unless the sole purpose of the requested treatment is to create records for disclosure to someone else. (i.e. Pre-employment, workman's compensation, work capacity evaluation)
- I understand that this authorization may be revoked in writing and delivered to Dover Women's Health at any time. Your written revocation will become effective when we receive it. Although revocation will not be effective as to the disclosure of records whose release I have previously signed, or where action has been taken in reliance on an authorization I have signed. If you are providing this authorization to obtain insurance coverage you may not have the

right to revoke the authorization in the future to the extent that it pertains to the insurer's right under law to contest a claim under your insurance policy. If you wish to revoke this authorization, please send your written request to;

Dover Women's Health
700 Central Ave
Dover NH 03820

- I understand that if I authorize disclosure of protected health information, the recipient may further disclose this Information, and Federal law will no longer protect it
- I understand that I have the right to inspect or copy the information I am consenting to release within the established policies of Dover Women's Health.
- For marketing authorizations only: I understand that Dover Women's Health will/will not (circle one) receive compensation from a third party, whether monetary or otherwise, as a result of its use or disclosure, pursuant to this Authorization, of information about me.
- Once this authorization has expired, we will no longer use or disclose our health information for the purpose listed in this authorization unless you sign a new form. **This Authorization expires:**
 - a. On the following date: ____/____/____
 - b. When the following event occurs: _____
 - c. ____ Check here if this authorization is for the purpose of permitting the use or disclosure of PHI for the purpose of research, in which case this Authorization does not expire.
 - d. If none of (a) through (b) is completed above, this Authorization will expire 12 months from the date this form is signed.

Signature of Patient or Legal Representative/Guardian

_____/_____/_____
Date

Authority or Relationship of Representative
(Attach copy of documentation of authority)

To Recipient of this authorization: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal law prohibits you from making any further disclosures of this information without the specific writing authorization to which it pertains.

Authority: This form is designed to comply with CFR 45 Section 164.508

Copy Provided: I have received a copy of my authorization to release my PHI
Initial of signer:
Date: ____/____/____

Fee for copying records: When a patient personally requests a copy of their medical records, a fee of 50 cents per page (minimum \$15) will be charged. Medical records will be copied and forwarded to another medical office at no charge. Please contact our office for further details.