NEW HAMPSHIRE HOSPITAL

Attn: Health Information Department
36 Clinton St. Concord, NH 03301
Telephone 603-271-5300
Fax 603-271-5784

Patient's Name _____ Date of Birth _____

I authorize NH Hospital to disclose my protected health information as described below for the purposes of:

☐ Continuing Care ☐ Other _____

For Dates of Care From: _____ **to:** _____ **OR** ☐ **Most Recent Admission/Discharge**

Disclose To: Name _____

Street_____

City/State _____

Phone Number: _____ Fax Number _____

Information To Disclose to the Above Person or Organization:

☐ Record Abstract (Discharge Summary, Discharge Medication List, History/Physical, Admitting Psychiatric Evaluation)
☐ Discharge Summary ☐ Physical Exam ☐ Admission Psych Assessment ☐ Social Service Assessment
☐ Psychological/Neurological Testing ☐ Lab or Radiology ☐ EKG/EEG ☐ Immunization Status
☐ Other (list): _____

By signing this Authorization for Disclosure of Protected Health Information, I understand that:

1. A Photocopy or fax of this authorization shall be as valid as the original.
2. New Hampshire Hospital will continue to treat me even if I decline to sign this authorization.
3. The disclosed information might be re-disclosed and would no longer be protected by federal or state laws.
4. Under the NH Division of Behavioral Health regulation, He-M 311, (after May 1982): NH Hospital is obliged to disclose any information in its possession with a properly executed authorization.
5. The authorization expires one year from the date of signature. EXCEPTION: Disclosure of information to/from Community Mental Health Centers shall be a length of time to correspond with the term of any probate commitment (Conditional Discharge) to facilitate continued communication.
6. Information disclosed may include psychiatric, substance/sexual abuse, HIV infection or testing for HIV
7. Medical/psychiatric information may be disclosed via fax or secure electronic transmission
8. I authorize disclosure of medical records identified as protected health information relating to a finding of No Probable Cause in accordance with NH RSA 135-C. Any court documents ordering me to be confined at NHH must be obtained from the issuing court, as the Hospital is not authorized to disclose those legal documents
9. I can revoke this authorization at any time by a written request to the Health Information Department of NH Hospital. The revocation does not apply to any information released prior to the date of revocation. The revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
10. I am entitled to a copy of this authorization after I sign it.

.

Complete this section ONLY if a <u>minor</u> has been treated for a sexually transmitted disease pursuant to RSA 141-C: 18, II
A competent minor aged 14 or older may consent to treatment for a sexually transmitted disease. Therefore, specific authorization of the minor is required for the disclosure of that information. If the parent/guardian authorized the treatment they would also authorize the disclosure of information.

____ **Patient Initials** ☐ **Yes or** ☐ **No** **OR** _____ **Parent/Guardian Initials** ☐ **Yes or** ☐ **No**

_____ _____ _____

Signature of Patient/Legally Authorized Representative **Relationship if not signed by the patient** **Date**

Please include a phone number where we may reach you if we have questions about your request.

Telephone _____

NEW HAMPSHIRE HOSPITAL
Authorization for Disclosure of
Protected Health Information

PATIENT IDENTIFICATION

MR # 001
Revised 8/12/16
File in Legal Section