Protected Health Information Release Authorization

Patient Name: ____DOB ___________________________

1. **This will authorize Garrison Women's Health, to use and/or disclose my protected health information for the following purpose**:
   - ❑ Continuation of Medical Care
   - ❑ Transfer of Care. **REASON**: ____
   - ❑ Other (please specify): ____

Please release my Information	From:	To:
Name		
Street Address		
City, State, Zip		
Phone		
Fax		

2. **Information to Be Disclosed**:
   - ❑ Mammography Films
   - ❑ Mammography Films and Reports
   - ❑ Bone Density Reports

Note: Information to be disclosed may include, as applicable, information related to mental health, drug or alcohol treatment, genetic testing, HIV/AIDS, and psychotherapy notes.

❑**All Studies**

OR

❑**Records** from the following dates: _______________ to _______________.

OR

❑**All necessary records for continuation of medical care**

If the choice I made above contains certain information I **do not want** disclosed, I will list it below:

____

____

3. **Method of Delivery**

❑Mail to receiving entity above ❑I will pick up

❑Designee will pick up (specify below) ❑Other _______________

I allow __________________________, my designee, to pick up the medical records identified above.

Print Name

My designee may pick up my medical records for the time period I have checked below:

- ❑ One time only − once my designee picks up my medical records, that person may not pick up my medical records in the future unless I sign another copy of this document.
- ❑ Indefinitely − my designee may pick up my medical records until I revoke the authority of my designee or until this PHI Release form expires or is revoked by me.

- I MAY REFUSE TO SIGN THIS AUTHORIZATION. New England Mammography, and its related entities, 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. For example, the Practice may refuse to perform a pre-employment physical for me if I refuse to authorize the release of information obtained during that physical to my employer.
- I may revoke this Authorization at any time, in writing, except to the extent that we have already relied upon it in making a disclosure. Your written revocation will become effective when we receive it. 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: **Garrison Women's Health, Attn: Ashlee Wilson 770 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 may no longer protect it.
- I understand that I have the right to inspect or receive a copy of the information I am consenting to release within the established policies of New England Mammography, and its related entities.
- This authorization will automatically expire **12 months from the date signed** unless limited to the following date/event ____.

____________________	____	____________
Printed Name	Signature of Patient or Legal Representative/Guardian **(Legal Handwritten Signature Accepted Only)**	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. If the information is drug or alcohol abuse treatment information covered by 42 CFR Part 2, 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

A copy of this authorization must be provided to the patient.

For Office use only:

Request Processed By: Staff Initials_____________ Date________________ Approved By: ________________________

For Medical Information use only:

□ Patient picked up □ Mailed to patient □ Mailed to receiving entity □ Other_______________ Date: __________________

Completed By: Staff Initials______________ Date_________________

□ ***A copy of this signed authorization <u>has</u> been included with the records provided to the patient.***

For Designees/Patients picking up records only (signature will be obtained by Medical Information at time of pick up):

Signature _____________________________________ Printed Name __________________________ Date________________