

Speare Memorial Hospital –
A Critical Access Hospital
And Affiliated Practices
16 Hospital Road
Plymouth, NH 03264

Patient Name: _____
Address: _____

Date of Birth: _____
MR# _____

**AUTHORIZATION TO USE & DISCLOSE
HEALTH INFORMATION**

I authorize the use or disclosure of the above named individual's health information as described below.
The following individual(s) or organization(s) are authorized to make the disclosure:

Individual/Organization: _____

Address: _____

Phone: _____ Fax: _____

The type and amount of information to be disclosed is as follows:

- Current problem list
- Current medication list
- Current allergy list
- Office visit notes for the last 2 years
- Consult notes for the last 3 years
- Routine labs for the last 3 years and most recent specialty labs
- Most recent imaging studies from the last 5 years
- Most recent cardio/pulmonary studies for the last 5 years (PFTs, ECG, echo and/or stress test)
- Most recent pap result (if applicable)
- Most recent mammogram (if applicable)
- Most recent colonoscopy including pathology results (if applicable)
(Alternatively most recent Cologard or FIT testing)
- All vaccinations (summary schedule preferred)
(Only need most recent flu vaccination)
- Hospital discharge summaries (or discharge note) for the last 3 years
- ER provider notes for the last year
- Operative reports (major surgeries only) for the last 10 years
- Pathology reports for the last 10 years
- Other _____

This information may be disclosed to and used by the following individual or organization:

Speare Primary Care
16 Hospital Road
Plymouth, NH 03264
603-536-1881 (Telephone)
603-238-2198 (Fax)

The **purpose** of this release is to **expedite** the **transfer of patient care**

I understand that I have a right to **revoke** this authorization at any time. I understand that if I revoke this authorization I must do so **in writing and present my written revocation to the health information** management department. I understand that the revocation will not apply to information that has already been released in response

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to this authorization. I understand that 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.

This authorization expires in one year from today date: _____

If I have been diagnosed or treated for any of the following, I understand Speare Memorial Hospital and Affiliated Practices needs my specific consent to disclose related information. I am specifically authorizing the release of information relating to: **(please sign if checked)**

I authorize use/disclosure of information which refers to treatment or diagnosis of **DRUG OR ALCOHOL ABUSE**. Such information may not be re-disclosed by the recipient without my specific written consent.

I authorize use/disclosure of information which refers to treatment or diagnosis of **MENTAL HEALTH**. I do not wish to review such information prior to its release.

I authorize use/disclosure of information which refers to treatment or diagnosis of **Communicable or Infectious Diseases, HIV/AIDS (Acquired Immune Deficiency Syndrome)**. Such information may not be re-disclosed by the recipient without my specific written authorization.

I authorize the use/disclosure of health information related to **GENETIC TESTING**.

Signature of Patient or Legal Representative

Date

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized **redisclosure** and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Speare Memorial Hospital Health Information Services or Affiliated Practices that I was seen at and treated.

I understand that I am entitled to a **copy** of this authorization form.

Signature of Patient or Legal Representative

Date

Authority / Relationship to Patient

Witness to Signature

Identification Verified