GRANITE STATE PAIN ASSOCIATES
GRANITE STATE SURGICENTER

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# Protected Health Information (PHI) Release Authorization

Name (First, MI, Last)_____DOB _____-_____-_____
Mailing Address_____City/State/Zip_____
Phone Number (H)_____ (C)_____ (W)_____

***I hereby authorize disclosure of my Protected Health information as follows:***

**Specify REASON for Release:** __ Transfer of Care __ Ongoing Care/Specialist __ Legal __ Personal
__ Billing/Insurance __ Other: _____

**Specify WHO: Obtain FROM:** ___ Our Organization **Release TO:** ___ Our Organization
Facility & Person:_____ Facility & Person:_____
Address: _____ Address: _____
_____ _____
Phone: _____ Fax: _____ Phone: _____Fax: _____

**Specify DATES & RECORDS to be released: Mark or describe**

**Specify Dates of Service:** from _____ to _____

**Specify Items** (may include information related to Mental Health, Drug/Alcohol, Genetic Testing, HIV/AIDS, & External Records)

____Office Visit Notes ____Lab Results ____Imaging Reports ____Procedure/Surgery Notes
____Consultations ____Test Results ____Medications/Pharmacy ____Billing Reports
____HIV/AIDS ____Alcohol/Drug/Substance Abuse ____Genetic Testing ____Mental Health
____ Entire medical record (includes Mental Health, Alcohol/Drug/Substance, Genetic, HIV/AIDS, & External Records)
____ Other: _____
_____

**I, the Patient, OR Authorized Person of Patient, UNDERSTAND**:

- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- I may choose to refuse to sign this form.
- I have the right to inspect or copy the information I am consenting to release within the organization's established policies.
- My right to healthcare treatment is not conditioned on this authorization.
- I understand that disclosure of this information carries with it the potential for re-disclosure and the information may not be protected by federal/state confidentiality rules.
- There may be a charge for the requested records.
- This release will expire 12 months after date of signature unless date is specified: _____
- Unless otherwise specified, release may be in any reasonable manner including: verbal, paper, unencrypted fax/electronic.

**PATIENT/Authorized Person SIGNATURE: _____ Date: _____**

**Authorized Person NAME** (print)**: _____ Relationship: _____**

**For Substance Abuse Disorder** treatment information (covered by 42 CFR Part 2): Notice to recipient of protected information: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.