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:

FOR THE DATES OF SERVICES from _____ to _____

TYPE OF RECORDS REQUESTED: (please check your request)

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

____Office Visit Notes ____Lab Results ____Imaging Reports ____Procedure/Surgery Notes

____Consultations ____Test Results ____Medications/Pharmacy ____Billing Reports

____Mental Health ___HIV/AIDS ____Alcohol/Drug/Substance Abuse ____Genetic Testing ____Psychotherapy

___ Entire medical record (includes Mental Health, Alcohol/Drug/Substance, Genetic, HIV/AIDS, Psychotherapy, & External Records)

___ Other: _____

_____

TO BE OBTAINED FROM: ___ Our Organization

or Facility:_____

Address: _____

_____

Phone: _____ Fax: _____

TO BE RELEASED TO: ___ Our Organization

or Facility: _____

Address: _____

_____

Phone: _____Fax: _____

REASON FOR RELEASE: (Check only one) ___ Transfer of Care ____ Ongoing Care/Specialist

____ Legal ___ Personal ____ Billing/Insurance ____ Other: _____

I, THE PATIENT OR LEGAL REPRESENTATIVE 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/REPRESENTATIVE SIGNATURE: _____ Date: _____

Legal Representative Name: _____ Relationship: _____

Drug or Alcohol Abuse treatment information (covered by 42 CFR Part 2): The Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CPR Part 2. A general authorization for the release of medical or other information is not sufficient of this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.