GRANITE STATE PAIN ASSOCIATES
GRANITE STATE SURGICENTER

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Protected Health Information (PHI) Release Authorization

Name (First, MI, Last)_____DOB _____-_____-_____

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

Granite State Pain Associates

To: **Entity/Name**: _____ **For:** ___Transfer of Care

Check ☐ Release To: Address: _____ ___ Legal ___ Personal

Only ☐ Obtain From: Address: _____ ___ Ongoing Care

One ☐ Discuss With: Phone: _____ ___ Billing/Insurance

☐ Release & Discuss: Fax: _____ ___ Other _____

DATES of Service to release: From: _____ to _____ (May use a future date up to 12months from today)

RECORDS to be released/discussed: Note: Information to be disclosed may include information related to HIV/AIDS, mental health, drug/alcohol/substance abuse, psychiatric care, STDs, genetic testing, pregnancy, prenatal care, birth control, abortion, and family planning.

☐ Medical Visits/ Information, including, but not limited to: my symptoms, diagnosis, medications and treatment plan.
☐ Behavioral health Visits/Information, including, but not limited to: my symptoms, diagnosis, medications and treatment plan
☐ Lab results, Drug/Alcohol Screening and other test results
☐ Imaging/Diagnostic Reports ☐ Procedure/Surgery Notes ☐ Medications/Pharmacy
☐ Alcohol/Drug/Substance Abuse ☐ HIV/AIDS ☐ Genetic Testing
☐ Billing and Payment Information (including, but not limited to: balances, insurance & bills)
☐ Appointments/Attendance: including, but not limited to: schedule, verify, cancel, etc
☐ Entire medical record (includes Mental Health, Alcohol/Drug/Substance, Genetic, HIV/AIDS, & External Records). Fees may apply
☐ Other (be specific) _____

If releasing to self: METHOD of Delivery: ____ Send via Patient Portal (I have an account) ____ I will pick up ____ Mail

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

- This release will expire 12 months after date of signature unless date is specified: _____
- 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.
- Unless otherwise specified, release may be in any reasonable manner including: paper, unencrypted fax/electronic.

PATIENT/Authorized Person SIGNATURE: _____ Date: _____

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

For Substance Abuse Disorder Program 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.