

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**

1) 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:

- Speare Memorial Hospital**
- Tenney Mountain Internal Medicine**
- Plymouth Orthopedics and Sports Medicine Clinic**
- Plymouth General Surgery**
- Plymouth OBGYN**
- Gennaro Family Practice**
- White Mountain Eye Care**

Other:
Dr Name _____
Address _____

Phone _____
Fax _____

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

(Please Specify Applicable Dates, Illnesses, or Other Information, if Necessary)

- ___ Most recent history and physical
- ___ Most recent discharge summary
- ___ Emergency Room Visit(s) (date) _____ to (date) _____
- ___ Laboratory results from (date) _____ to (date) _____
- ___ X-ray and imaging reports from (date) _____ to (date) _____
- ___ Radiology Films /CD from (date) _____ to (date) _____
- ___ Consultation reports from (doctors' names) _____
- ___ Specific illness or injury (specify) _____
- ___ Entire record
- ___ **Transfer of care** (effective date): _____
- ___ Other _____

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

Name: _____
Mailing Address: _____

For the **purpose of: Continuation of 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 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: _____

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**

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