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. Unless otherwise revoked, this authorization will **expire** on the following date, event, or condition:

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_____. If I fail to specify an expiration date, event or condition, this authorization will **expire in six months**.

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 may cross out any of the following, which do not apply.

1. I authorize 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.

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

3. I authorize 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 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