**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**
[ ] **Speare Primary Care**
[ ] **Plymouth Orthopedics and Sports Medicine Clinic**
[ ] **Plymouth General Surgery**
[ ] **Plymouth OBGYN**
[ ] **White Mountain Eye Care**
[ ] **Plymouth Pediatrics**

[ ] **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: _________________________

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**Patient Name:** ______________________
**Address:** ___________________________
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**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**