

Authorization to Disclose Protected Health or Billing Information

Patient Information: I give permission to release the health information of:

(One patient per form)

Patient Name: _____
 Street Address: _____
 City, State, Zip: _____
 Email address: _____

Date of birth: _____
 Last 4 numbers of SSN: _____
 Telephone: () _____

Although Highland Avenue Primary Care will use reasonable means to protect the security and confidentiality of emails sent and received, we cannot guarantee the security and confidentiality of all email communications.

Release Information From: _____ (list applicable Facility(s) and/or Practice(s)) _____ _____	Release Information To: _____ (Name of facility, person, company) (Relationship) _____ (Street address or PO Box, City, State, Zip code) _____ (Phone number) (Fax number)
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Purpose of Release (check reason): Request of individual / personal Insurance Disability Workers Compensation
 Legal purpose including discussions & proceedings Other: _____

Must fill in dates of treatment for records to be released: Treatment dates FROM: _____ TO: _____

Hospital (check all that may apply):

Hospital Abstract

<input type="checkbox"/> History & Physical	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Emergency Record
<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Cardiac Reports/EKG
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Laboratory Reports
<input type="checkbox"/> Diagnostic Test Results	<input type="checkbox"/> Radiology/X-Ray Reports
<input type="checkbox"/> Medications	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Allergies	<input type="checkbox"/> Billing Information
<input type="checkbox"/> Physician Orders	<input type="checkbox"/> Other: _____

Entire Record (not including psychotherapy notes)

Office/Clinic (check all that may apply):

Office / Clinic Abstract

<input type="checkbox"/> Office Visits
<input type="checkbox"/> Physical Exam
<input type="checkbox"/> Consultation Reports
<input type="checkbox"/> Diagnostic Test Results
<input type="checkbox"/> Laboratory Reports
<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> Medications
<input type="checkbox"/> Billing Information
<input type="checkbox"/> Other: _____

Entire Record (not including psychotherapy notes)

Format (only select one):
 Paper copy (charges may apply) Electronic copy
 CD (charges may apply) Other: _____

Delivery Method:
 Reg. US Mail Pick-up Email Fax
 Other: _____

- I understand that:**
- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.
 - This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.
 - Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
 - Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
 - A fee may be charged for providing the protected health information.
 - I have a right to receive a copy of this form upon request.

This permission expires 90 days after the date of my signature unless another date or event is written here: _____

Signature: _____ **Print name:** _____ **Date/Time:** _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.

Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):

Healthcare Agent/POA Guardian Executor/Administrator/Attorney in Fact Parent Next of Kin
 Other: _____

Signature of minor: _____ **Print name:** _____ **Date/Time:** _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:
 Interpreter Accepted _____ Interpreter Refused
 (Name/Number of Person/Services Chosen/Used)

For office use only
 Date of release: _____ via mail fax other _____ ID verified DL/Other ID _____
 NH Employee Name & Title: _____ NH Employee User ID: _____ Date/Time: _____



Authorization to Disclose Protected Health or Billing Information

Patient Name: _____
 DOB: _____
 Or label
 Name / MR# / Label