PORTSMOUTH REGIONAL HOSPITAL
Authorization for Use and Disclosure of Protected Health Information (PHI)

Patient Legal Name	Birthdate	Social Security No.

Address____Telephone No.______________________

City__________________________________State________________Zip Code____________________

I hereby authorize Portsmouth Regional Hospital to disclose medical record information and/or protected health information of the patient listed above to: and/or obtain from: (please check)_____

____
Name / Title

____
Address *Phone* *Fax*

Purpose:____

Dates of services at PRH you are requesting: ____

Selected Portions of PHI:

❑ Abstract/Pertinent	❑ Radiology	❑ Progress Notes
❑ Emergency Room	❑ Lab	❑ Physician Orders
❑ H & P	❑ Cardiac Studies	❑ Psychiatric records
❑ Consult Report	❑ Face Sheet	❑ Billing record
❑ Operative Report	❑ Nursing Notes	❑ Other______________________
❑ Rehab Services	❑ Medication Record	❑ Other______________________

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information unless initialed here. I do not consent ______.
Initials

Expiration: This authorization shall expire upon this expiration Date or Event: __________________
Not to exceed 60 days.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I may receive a copy of this form after I sign it.

I have read the above and authorize the disclosure of the protected health information as stated.

____________________ ____ ____________________
Date | Signature of Patient/Parent/Patient Representative | Relationship to Patient

Durable Power of Attorney for Healthcare Release: I am signing as the agent for the patient and declare that the attached Durable Power of Attorney for Healthcare is still in effect, that I am authorized to obtain the information I have requested, and I will only use the information I obtain for the "purpose of making health care decisions for the patient" as outlined in NH RSA137-J:7.

__________________ _____ ____
Date | Signature of agent of the Durable Power of Attorney for Healthcare

Health Information Management Department, Portsmouth Regional Hospital, 333 Borthwick Ave., Portsmouth, NH 03801 Telephone #: (603) 433-4044 Facsimile # (603) 433-4917

Original – facility Copy – individual (pt or pt rep) **Mail____Pick Up _____Fax ____Fax #: ____________________**