



HIPAA AUTHORIZATION for RELEASE of PATIENT RECORDS

Date:		
Month	Day	Year

This authorization expires

Date:		
Month	Day	Year

(If no date is inserted, this authorization expires one year after the date signed.)

Patient Information			
_____	_____	_____	_____
Last Name	First Name	Middle Initial	Date of Birth
_____			_____
Address			Month Day Year

Phone number			

I hereby authorize New Hampshire Orthopaedic Center to release the following records (check relevant boxes):

- my entire medical record
- or*
- records relating to the following injury/condition only: _____
- office notes
- radiology reports
- operative notes
- other records: _____

UNLESS MY INITIALS APPEAR BELOW, I specifically and voluntarily authorize New Hampshire Orthopaedic Center to include in the release of records any information relating to the following issues, if applicable. My initials indicate I **do not** consent to the release of records relating to the following:

- _____ **mental health illness/diagnosis**
- _____ **alcohol/drug abuse/treatment**
- _____ **HIV/AIDS test results/diagnosis**
- _____ **communicable diseases.**

Person or organization to whom the information is being released			
_____		_____	
Name		Organization	
_____		_____	_____
Address		City	State Zip
_____		_____	_____
Phone		Fax	

The purpose of the release of my medical records is:
(Note, patient may decline to specify purpose)

- I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.
- I understand that there may be medical records from another doctor or another medical facility in my chart.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- I understand that I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.
- I have read and understood this authorization, and hereby release New Hampshire Orthopaedic Center from any and all legal liability arising from the release of records authorized by this authorization, or from any re-disclosure of the records.

Signature of Patient

Name of Witness

Authority to Act

In accordance with our policy, if you are releasing records to yourself, they will be mailed to you and will arrive in 7-10 business days. Records will NOT be available for pickup in any of our offices.

Pursuant to New Hampshire State Law Chapter 332-1 Section 332-1:1 you will be charged \$15.00 for the first 30 pages and \$0.50 for each additional page, plus postage. If you have any questions regarding this policy please contact our office.