GI Associates of New Hampshire

60 Commercial Street, Suite 404
Concord, NH 03301
Phone: 603-228-1763 Fax: 603-228-7088

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information:

Name		
Street Address		
City	State	Zip Code
DOB	Phone Number	

Records Released To:

Name		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

Information To Be Released:

❑ Complete Copy of All Records ❑ Procedure Reports ❑ Pathology Reports
❑ Lab Reports ❑ Office Visits ❑ Inpatient/Outpatient Records
❑ Other (please specify) _____

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information derived above may be re-disclosed and no longer protected by those regulations.

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 payments or my eligibility of benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by notifying GI Associates of NH except to the extent that action has been taken in reliance on this authorization. This authorization expires one year from date of signature.

I acknowledge that the data to be released may include material that is protected by law.
My initials and signature authorize release of the following type of information:

_____ drug/alcohol abuse information _____ mental health information
_____ HIV information _____ genetic testing

_____

Signature of Patient or Representative **Date**

_____

Name of Personal Representative (if applicable) Relationship to Patient