Allergy Associates of New Hampshire

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☐ 51 Webb Place, Suite 230, Dover, NH 03820 603-343-4649 Fax 603-343-5367

Authorization to Use and Disclose Protected Health Information

Patient Information

Patient Name: _____ Date of Birth: _____
Patient Address: _____ Phone Number: _____
City:_____ State: _____ Zip: _____ Email: _____

I Authorize Allergy Associates of NH to: ☐ Release medical information to: ☐ Obtain medical information from:

Name/Facility: _____ Phone Number: _____
Address: _____ Fax Number: _____
City:_____ State: _____ Zip: _____ Email: _____

Purpose of Release: ☐ Continuation of Care ☐ Transfer of Care ☐ Legal ☐ Insurance
☐ Personal ☐ Other: _____

Medical Information to be Released

☐ Complete Record ☐ Last 1 year of records ☐ Last 3 years of records
☐ Progress Notes ☐ Consultation Reports ☐ Lab/Imaging Reports
☐ Other (please specify): _____

It is extremely important that you check DO or DO NOT for each item listed below. Please do not skip any item as it could impact our ability to fulfill your request and cause additional delays.

I ☐ **DO** ☐ **DO NOT** want detailed Behavioral/Mental Health records released
I ☐ **DO** ☐ **DO NOT** want detailed HIV/Aides/Sexually Transmitted Disease records released
I ☐ **DO** ☐ **DO NOT** want detailed Alcohol/Substance Abuse records released

Authorization

This authorization is valid for **one year** and may be revoked at any time in writing prior to the expiration date, except to the extent that Allergy Associates of NH has already used or disclosed the information in reliance on my authorization.

I understand that the recipient of some information disclosed under this authorization may re-disclose this information, and the information may be protected by federal or state confidentiality laws.

I understand that NH law permits Allergy Associates of NH to charge for the cost of copying the information released under this authorization, up to $15 for the first 30 pages or $.50 per page, whichever is greater. (NH RSA 332-I:1)

_____ _____ _____
Signature of Patient/Authorized Representative **Relationship** **Date**