Hampton Internal Medicine

Medical Records Release Form

Patient Name:	**Birth Date:**	**Social Security (optional)**	
Requestors information (if requestor is not the patient)	**Name:**	**Relation:**	**Phone:**

Hampton Internal Medicine **55 High Street Suite 201** **Hampton, NH 03842** **Phone 603-929-2137** **Fax 603-929-7482**	☐ **Records to be sent to:** ☐ **Records to be received from:** **Name:** **Street:** **City:** **State:** **Zip:** **Phone:** **Fax:**

This authorization will expire on the following: (Fill in Date or Event below, not both)

Date: Event:

Purpose of Disclosure: ☐ Transfer of Care (new PCP) ☐ Personal Use ☐ Other:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description	**Date(s)**	**Description**	**Date(s) & Where**	**Description**	**Date(s) & Who or Where**
☐ All PHI in record		☐ Mammogram		☐ Laboratory Results	
☐ Immunization Record		☐ X-Rays		☐ Specialist Records	
☐ Medication List		☐ Ultrasound		☐ Hospital Records	
☐ Office Notes		☐ MRI		☐ OTHER :	
☐ Annual Physical		☐ Cat Scan			
☐ Pap Smear Results		☐ Diagnostic Testing			

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

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 the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Is the request of PHI for the purpose of marketing?

If yes, the health plan or health care provider must complete this section, otherwise skip to Signatures

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?	☐ Yes ☐ No
If yes, describe:	

Signatures

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

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

Fee for copying records: When a patient requests to personally obtain copies of medical records, a fee will be charged to the patient. In the event of a transfer of care, Hampton Internal Medicine will provide copies of the records to their new primary care office at no charge to the patient. Please contact our medical records department for further details.