CORE PHYSICIANS
an exeter health resource | The Art of Wellness

Authorization to Use and Disclose Protected Health Information

Location Name: _____ **Practice ID#:** _____

Address: _____

City, State, Zip: _____

Patient Information

Patient Name (Please Print): _____ Date of Birth: _____

Patient Address: _____ Phone #'s: _____

City: _____ State: _____ Zip: _____ EMAIL: _____

I hereby Authorize CORE Physicians to release my medical information to:

Name/Facility: _____ Attention: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____ Fax #: _____

Purpose of Request:
○ Location/Convenience ○ Provider Leaving ○ Legal ○ Dissatisfied with Provider/Practice
○ Change of Health Insurance/Financial ○ Referral/Second Opinion ○ Dual Residencies (not transferring care)

Specific Records/Report(s) to be released:

IMPORTANT: *A Copy Fee may apply if you are seeking a copy of your medical record for personal use, or you are leaving Core Physicians. Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. At no time will the cost-based fees exceed New Hampshire law (RSA 332-1, Section 1). Please allow seven to ten business days for the processing of this request.*

○ Please provide a 2 year abstract of my records.
○ Please provide a copy of my full record.
○ Other - please be specific, include dates and Providers in box to the right.

Restricted Authorization to Release Protected Information:

STOP **IMPORTANT -** It is extremely important that you select either you "**DO**" or "**DO NOT**" for each item contained in this section *Authorization to Release Protected Information*. Please do not skip any line item as it could impact our ability to fulfill your request and cause additional delays.

Release Records? Check one.

I ☐ **DO** ☐ **DO NOT** want **Mental/Behavior Health or Disability Services Provider Documentation *** released
I ☐ **DO** ☐ **DO NOT** want **HIV/AIDS Screening Test Results** released
I ☐ **DO** ☐ **DO NOT** want information about **Alcohol and/or Substance Abuse Treatment** *** released
I ☐ **DO** ☐ **DO NOT** want **Genetic Testing/Test Results **** released
I ☐ **DO** ☐ **DO NOT** want **Confidential Communications** released
I ☐ **DO** ☐ **DO NOT** want information about **Rape/Sexual Assault Victim's Counseling** released
I ☐ **DO** ☐ **DO NOT** want **Child/Elder Abuse or Neglect & Abuse of an Adult with a Disability** released
I ☐ **DO** ☐ **DO NOT** want information about **Sexually Transmitted Disease (STDs)** released
I ☐ **DO** ☐ **DO NOT** want information about **Domestic Violence Victim's Counseling** released
I ☐ **DO** ☐ **DO NOT** want information about **Abortion** released

* This Authorization is not valid for use or disclosure of psychotherapy notes.

** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not a test done to diagnose a current condition or problem. This includes information related to the testing of embryos created during IVF.

*** Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment" (42 CFR Part 2). Does not include records created or maintained by a general medical facility.

Sign Here **Date Here**

Signature of Patient **Date**

Signature of Personal Representative **Date** **Relationship to patient or authority to act for patient**

Term: Unless I otherwise revoke this authorization in writing, this authorization will automatically expire after the use or disclosure requested herein is made, unless otherwise specified.

Revocation: I understand that I may revoke this Authorization at any time by requesting it of CORE Physicians in writing at the address listed below. The revocation will be effective immediately upon CORE Physicians' receipt of my written notice. I understand that the revocation will not have any effect on any action taken by CORE Physicians in reliance on this Authorization before it received my written notice of revocation. Written Notice is to be mailed to: Privacy Officer, Core Physicians, 7 Holland Way, 1st Floor, Exeter, NH 03833.

Effect on Treatment: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment at CORE Physicians.

Potential for Redisclosure: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state Privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by CORE.

Access: I understand that in certain circumstances CORE Physicians has the right to deny me access to all or portions of my Protected Health Information and must notify me in writing of any such denials.