CORE PHYSICIANS
an exeter health resource | The Art of Wellness

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO CORE PHYSICIANS

Patient Name: _____ **Date of Birth:** _____

Address: _____

FROM

I authorize ***Practice/Provider Name***: _____

_____ (_____)_____ (_____)_____

Office Address, City, State, Zip Code ***Phone*** ***Fax***

TO

to release my protected health information (medical records) described below to Core Physicians (Office Details below):

_____

_____ (_____)_____ (_____)_____

Office Address, City, State, Zip Code ***Phone*** ***Fax***

RELEASE PURPOSE

For the following purpose: ☐ Continuing Medical Care ☐ Permanently Transfer to Another Provider ☐ Personal

☐ Other _____

RECORDS TO BE RELEASED

Timeframe to Be Released

Date range: _____ or Years (3 years is recommended): _____

Document/Note(s) (check all that apply)

☐ Complete Medical Record
☐ Office Notes
☐ Outpatient Provider/Clinic Notes
☐ Therapy Notes (physical, occupational, speech)
☐ Inpatient notes/Discharge Summaries
☐ Operative/Procedure Notes
☐ Emergency Department/Urgent Care Notes
☐ Lab Results
☐ Pathology Reports
☐ Microbiology/Culture Reports
☐ Radiology Reports
☐ Radiology Image(s), specify: _____
☐ Other, specify:_____

_____

If my initials appear below, I request that you do NOT send the following records:

_____, I **do not** authorize release of any records concerning drug or alcohol treatment and/or mental health treatment.

_____, I **do not** authorize the release of any records concerning genetic testing for the purposes set forth above.

_____, I **do not** authorize release of any records concerning my diagnosis of or treatment for HIV or AIDS, or contain some other reference to my identity as an HIV or AIDS patient for the purpose set forth above.

DELIVERY OF INFORMATION

Preferred Method:
☐ Mail ☐ Fax (listed above) ☐ Other, specify _____

Date Information Needed by (mm-dd-yyyy):

Format:
☐ Paper ☐ Electronic (.pdf file on CD) ☐ Other, specify _____

Separate request needs to be completed for each practice/specialty where patient wants records sent to Core

I understand that I may inspect or copy the protected health information described in this authorization.

I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of any care or treatment I receive through Core Physicians.

I understand that this authorization will remain in effect until the term of this authorization expires or I provide a written notice of its revocation to Core Physicians at 7 Holland Way, Exeter, NH 03833. This revocation will be effective immediately upon Core Physicians' receipt of my written notice, except 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.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I understand that by authorizing this release of my medical records, I also release Core Physicians from all legal responsibility or liability that may arise from the release of these records.

SIGNATURE

Patient Signature: _____ **Date:** _____

Legal Representative – Printed Name: _____ **Relationship:** _____

Legal Representative – Signature: _____ **Date:** _____

EXPIRATION: Unless I otherwise revoke this authorization in writing, this authorization will automatically expire after the obtainment is made, unless otherwise specified.

Separate request needs to be completed for each practice/specialty where patient wants records sent to Core