



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:

\_\_\_\_\_  
Office Address, City, State, Zip Code Phone Fax

For the following purpose (at patient's request is sufficient): \_\_\_\_\_

Date range of records requested (last 3 years is recommended): \_\_\_\_\_

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.

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.

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.

Received by (Core Physicians employee): \_\_\_\_\_