ENT ASSOCIATES OF NH - *A DEPARTMENT OF LRGH*
85 Spring Street Laconia NH, 03246
Telephone: 603.524.7402 ~ Toll-Free: 800.464.7402 ~ Fax: 603.524.0945

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

___ LRGH	___ ASC at Hillside	___ AOS
___ FRH	___ ASC at Laconia Clinic	**_X_ ENT**
___ LACONIA CLINIC	___ WESTSIDE	___ NEWFOUND

_____ _____ _____
Patient Full Name: Date of Birth: Medical Record No.

[ ] I hereby authorize _____ to

[ ] Send/Disclose Information to:	[ ] Receive Information From:
Name: _____	Name: _____
Address: _____	Address: _____
Phone Number: _____	Phone Number: _____
Fax Number: _____	Fax Number: _____
E-mail address: _____	E-mail address: _____

For the following purpose(s):
[ ] Current treatment [ ] Personal records [ ] Insurance [ ] Worker's Compensation

[ ] Provider transfer [ ] Attorney [ ] Other (specify) _____

Dates of service: _____

Type of information requested:
[ ] Abstract (includes any available documents or check only those documents needed):
[ ] Emergency Dept. Documentation

[ ] Discharge Summary	[ ] Laboratory Report	[ ] Physician Orders
[ ] History & Physical	[ ] Cardiology Report	[ ] Progress Notes
[ ] Consultation	[ ] Radiology Report (Lakes/Franklin)	[ ] Medication Records
[ ] Operative Report	[ ] Radiology Report (AOS)	[ ] Other:
[ ] Imaging CD/Film	[ ] Radiology Films/CD	_____
[ ] Imaging Report _____ Date of Imaging		

I UNDERSTAND THAT:

- Upon request, I can inspect or obtain a copy of the information I am authorizing to be released. A fee for the costs of processing this request may be charged
- Information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state laws.
- ENT Associates of NH – A Dept. of LRGH may utilize a trusted business associate to assist in fulfilling this request. If I have any questions about disclosure of my health information, I can contact the Release of Information staff of Health Information Management Services at 603-524-7402 X205.
- I can revoke this authorization at any time by submitting a request in writing to the Health Information Management Services at this office. This will not apply to any previously released information. I understand that this will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

The following types of information WILL BE INCLUDED UNLESS indicated by your initialing below:

Drug and/or alcohol treatment	**Initials _____**	**Psychiatric**	**Initials_____**
Abuse/sexual abuse	**Initials_____**	**Genetic Testing**	**Initials_____**
Sexually Transmitted Diseases	**Initials_____**	**History of abortion**	**Initials_____**
HIV (AIDS) testing/treatment	**Initials_____**		

This authorization expires six months from the date of signature, or on: _____
I have been offered a copy of this form.
Sign Here:

_____ _____ **Date/Time:** _____
Signature of patient or legal representative/guardian Authority or relationship of representative (Attach copy of documentation of authority)