HARBOUR WOMEN'S HEALTH

OBSTETRICS ● GYNECOLOGY ● UROGYNECOLOGY

Incoming Records Release
(Please Print)

Patient Name: _____ Previous Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Date of Birth: _____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

General information regarding this authorization:

This authorization permits the disclosure of your Protected Health Information (PHI). You have the right to revoke this authorization by providing the practice with written notice of revocation. The revocation will be effective upon receipt except with respect to uses or disclosures made prior to receipt and in reliance upon this authorization. This authorization expires 12 months from date hereof.

The following facility is requested and authorized to release my medical information:

Facility Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Please send medical records to:

Harbour Women's Health
155 Griffin Road
Portsmouth, NH 03801

Phone: 603-431-6011
Fax: 603-431-0229

I understand that my medical record may contain sensitive information relating to my diagnosis and treatment. The release of all such information including information related to drug and/or alcohol abuse, psychiatric treatment, sexually transmitted disease or other sensitive information if applicable is part of my medical record. I understand if I choose not to authorize all my medical records to be copied that partial or incomplete records will be labeled as such. I understand that refusal to authorize disclosure of all or some of the PHI may result in improper diagnosis or treatment, denial of possible insurance coverage or other adverse consequences.

Medical Information to be released:

_____ Last two years of office notes
_____Operative Reports
_____Pap Smear (Most Recent)
_____OB Records Only
_____Other:_____

Patient Signature: _____ Date: _____