HARBOUR WOMEN'S HEALTH
OBSTETRICS • GYNECOLOGY • UROGYNECOLOGY

155 Griffin Rd. Portsmouth, NH 03801
Phone: 603-431-6011 | Fax:603-431-6227

Print Name ______________________ Previous Name ______________________

Address: ______________________

City/State/Zip: ______________________

Phone Number: ______________________ DOB: ______________________

Authorization for use or disclosure of Protected Health Information (PHI)

Please read and complete *all* areas, incomplete forms will be returned to you. Allow 7-10 business days for processing.

This Authorization permits Harbour Women's Health to use or disclose your Protected Health Information (PHI) for purposes other than your treatment, payment to the Practice or Health care operations of the Practice. You have the right to revoke this Authorization by providing the Practice with written notice of revocation. The revocation will be effective upon receipt by the Practice except with respect to uses or disclosures made prior to receipt and in reliance upon this Authorization. This authorization expires 6 months from the date hereof. Please note that once the requested information is disclosed pursuant to this Authorization, the Practice will no longer have control over the information and there is a potential that it may be re-disclosed by the recipient and will no longer be protected by the privacy rules under the Health Insurance Portability and Accountability Act.

Harbour Women's Health is requested and authorized to release my medical information to:

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I AM LEAVING THE PRACTICE ☐
I AM NOT LEAVING THE PRACTICE ☐

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 and other adverse consequences.

Medical Information to be Released (check all that apply):

☐	Item	Other (Please specify):
☐	**Office notes**	______________________
☐	**Labs**	______________________
☐	**Diagnostic Imaging**	______________________
☐	**Office visit for date: __________**	______________________
☐	**Medical Record (past 3 years)**	______________________
☐	**Entire Medical Record**	

Authorization to release medical information

Signature____ **Date**____

Please note: Harbour Women's Health does not charge for copies of medical records associated to current patients. If you are not a patient of Harbour Women's Health there is a charge to copy and send your medical records as you have directed, which is applicable to NH state law.

Acknowledgement Regarding Release of HIV Infection Status Information

If I authorize the release of that portion of my medical records which contains information of HIV infection status (including the results of any HIV tests). I have dones so after having been advised, and with full understanding of the following facts:

- I have the right to elect whether to authorize the release of that portion of the medical record which contains HIV infection status information. If I elect to not authorize it's release, the custodian of the medical record release may release only that portion of the medical record which does not contain the HIV Infection Status Information.
- No medical record containing results of an HIV test may be disclosed without my consent except in certain cases specified by law (5m.d.s.a. 19023-D(2)-(3)) or pursuant to a court order issued upon showing of good cause.
- I may make a new election at any time, and thus prohibit any further releases or disclosure of HIV status information (except as mandated by law).

Signature: ______________________________

Date: ______________________________

Authorization for Release of Confidential HIV Information

I, ___________________________________ , hereby give permission to Harbour Women's Health, to release the information of my HIV infection status, including information pertaining to my HIV diagnosis and treatment and this information should be included with the medical records to be released to the party mentioned above.

Signature____ **Date**____

FOR OFFICE USE ONLY	Date received:	Date Processed:	Processed by: