MID-STATE HEALTH CENTER
Where your care comes together.

Mid-State Health Center:
Authorization to Release/ Disclose Protected Health Information

Patient Name: _____ **Other Name(s) Used:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

DOB: _____ **Phone Number:** _____ **Email Address:** _____

Instructions: Complete all applicable sections to have information disclosed **FROM** or **TO** Mid-State Health Center (MSHC). Refusal to complete this form will not affect the quality of or access to care, condition of treatment, payment, enrollment or eligibility for benefits.

Patient Notice – This Section Applies to All Requests

Note: This is a required section and must be completed in its entirety.

_____ I hereby authorize Mid-State Health Center to disclose/ release my protected health information (PHI) orally or in writing.

A. I request that the information be released for the following purpose: (**Initial** all that apply)

_____ Attorney/ Legal _____ Healthcare _____ Patient Record _____ Self-Pay
_____ Billing or Claims _____ Insurance _____ Review Request _____ Financial Aid
_____ Disability _____ Military _____ School _____ Transfer of Care
_____ Other: _____

B. I request that the information be released:

FROM: Name/ Facility Name: _____ Attn: _____
Address: _____City/ State: _____ Zip Code: _____
Phone: _____ Email: _____ Fax: _____

TO: Name/ Facility Name: _____ Attn: _____
Address: _____City/ State: _____ Zip Code: _____
Phone: _____ Email: _____ Fax: _____

TO: Name/ Facility Name: _____ Attn: _____
Address: _____City/ State: _____ Zip Code: _____
Phone: _____ Email: _____ Fax: _____

C. All **record requests** will be delivered in an electronic format (CD or via electronic file portal), unless otherwise specified. Please initial requested delivery method:

_____ Electronic File (Portal) _____ Fax _____ Postal Mail _____ In Office Pick-Up (valid photo ID required)*
_____ Other: _____

*To retrieve this information in person, a valid photo ID will be required for patient privacy and confidentiality purposes.

*I understand that a processing **fee may apply** for the requested information.

Section 1 – General Medical Records – Initial ONLY Boxes That Apply

A. Information to be released:

_____ Billing Records _____ Explanted Materials, Devices, Hardware _____ Immunizations _____ Patient Portal Notes
_____ Consultation Reports _____ Implant Records _____ Office Visit Notes
_____ Dental Reports _____ Family Studies/ Records _____ Laboratory _____ Operative Notes
_____ Demographics/ Face Sheet _____ History & Physical _____ Medication Lists _____ Pathology Report
_____ **Complete Medical Record** _____ Other: _____

B. Time period or date of information to be released: (MM/YY) From: _____ To: _____

C. Specific MSHC Treating Provider Name(s): _____ OR _____ All Medical Providers

D. Specific MSHC Clinic/ Service(s): _____ OR _____ All Medical Services

_____ I understand that my medical record may be incomplete and that additional documentation may be added when received

_____ I understand that psychotherapy notes will not be included unless authorized under 45 CFR 164.508(a)(2).

Records requested are in an electronic format (e.g. CD) unless paper specified above. Electronic signatures are not accepted.

Section 2 – Imaging/ Radiology Records - Initial ONLY Boxes That Apply

A. Information to be released:
_____ Dental Images _____ X-Ray(s) _____ Ultrasound _____Sonogram
_____ Reports ONLY _____Images ONLY _____ All Images and Reports

B. Time period or date of information to be released: (MM/YY) From: _____ To: _____

C. Specific MSHC Treating Provider Name(s): _____ OR _____ All Providers

D. All records will be delivered in an electronic format (CD or via electronic file portal), unless otherwise specified:
_____ Electronic _____ Paper **(Fee may Apply)**

E. Requested delivery method
_____ Electronic File (Portal) _____ Fax _____ Postal Mail _____ In Office Pick-Up (valid photo ID required)*
_____ Other: _____
*To retrieve this information in person, a valid photo ID will be required for patient privacy and confidentiality purposes.

Section 3 – Genetics, Psychiatry/ Behavioral Health Records – Initial Only Boxes that Apply

A. Genetics Records:
Date(s) of information to be released (MM/YY): From _____ To: _____ Physician Name(s): _____
_____ Specific Type/ Test: _____ OR _____ Complete Medical Record

B. Psychiatry/ Behavioral Health Records:
Date(s) of information to be released (MM/YY): From _____ To: _____ Physician Name: _____
_____Specify: _____ OR _____ Complete Behavioral Health Record
_____ **I understand that psychotherapy notes will not be included unless authorized under 45 CFR 164.508(a)(2).**

Section 4 – Student Health Record – Initial Only Boxes That Apply

A. Information to be Released:
_____ Immunization Record _____ Student Wellness and Counseling Record _____ Complete Medical Record

B. Date(s) of Information to be Released: From _____ To: _____ Physician Name(s): _____

Patient Acknowledgement – This Section Applies to All Requests

- **This authorization form does not authorize the release of Substance Use Therapy Records. A separate Authorization to Disclose Substance Use 42 Part 2 Form must be completed**.
- I understand that the information in my health record may include information relating or referencing: Genetic counseling; Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) treatment; history of drug or alcohol abuse; mental, behavioral health, or psychiatric care; and/or other sensitive information.
- I understand that I may revoke this authorization in writing at any time, except to the extent that MSHC has relied on this authorization. The written revocation should be addressed to the Health Information Management Department. Unless otherwise revoked, I understand that the date upon which this authorization **expires is 180 days** unless otherwise specified _____.
- I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA).

_____	_____	_____
Patient's Printed Name:	Patient's Signature:	Date:
_____	_____	_____
*Legal Representative's Printed Name:	Legal Representative's Signature	Date:

***Note: Proof of legal authority may be required for legal representatives**

Return Form to: **Mid-State Health Center**
Health Information Management – Release of Information
101 Boulder Point Drive, Suite 1
Plymouth, NH 03264
Phone: 603.536.4000 **Fax**: 603.536.4001
Email: medicalrecords@midstatehealth.org