AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

SEAPOINT FAMILY HEALTHCARE
264 LAFAYETTE ROAD, UNIT 9, PORTSMOUTH NH 03801
PHONE (603) 433-4774 • FAX (877) 795-5369

Name _____ DOB _____

Home Phone _____ Work Phone _____

( ) Please send my records to: **( ) Please get my records from:**

Name _____ Phone # _____ Fax # _____

Address _____

I authorize Seapoint Family Healthcare to use/disclose my complete medical record for the purpose of:

( ) Transfer of Care
( ) Communication with Other Providers
( ) Other _____

I authorize the release of the following sensitive information by checking below:

( ) Alcohol and/or Drug Abuse
( ) Psychiatric Care
( ) HIV/AIDS Related Illness

*FEDERAL CONFIDENTIALITY LAW-42 CFR PART 2 PROHIBITS REDISCLOSURE UNLESS EXPRESSLY PERMITTED IN WRITING BY THE PATIENT OR AS OTHERWISE PERMITTED BY 42 CFR PART 2

I understand these facts about the release of information:

- Consent for release of information is not required as a condition of treatment.
- This authorization may be revoked at any time except that information that has been disclosed prior to the date of revocation.
- If I authorize disclosure of protected health information, the recipient may further disclose this information, and federal law will no longer protect it.
- Once this authorization has expired we will no longer use or disclose your health information.
- The information may be released by any acceptable means, including by fax.
- This authorization will expire in 6 months (180 days) from the date below.
- A copy of this release is as valid as an original (e.g. fax).

Signature _____ Date _____
(Patient, or if minor, parent or legal guardian)