Access Sports Medicine & Orthopaedics

Authorization Form for Use and Disclosure of Protected Health Information

Patient's Full Name: _____ Date of Birth:

I hereby authorize Access Sports Medicine and Orthopaedics to use and/or disclose the **P**rotected **H**ealth **I**nformation described below to:_____

For the purpose (s) of ___ _____

P.H.I. (Specific information to be released: notes, reports, films, etc):

_____

_____

1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
2. I understand that Access Sports Medicine & Orthopaedics, Inc. will not condition treatment, payment or (if applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.
3. I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of Access Sports Medicine & Orthopaedics, Inc.. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
4. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

EXPIRATION DATE OR EVENT: This authorization will expire on (date no later than one year from now) _____.

(If no date is stated, this authorization expires six months from the date it was signed.)

1 Hampton Road, Suite 200 Exeter, NH 03833 (603) 775-7575 Fax- (603) 778-9680

COPY PROVIDED: Access Sports Medicine & Orthopaedics, Inc. shall provide a copy of this signed authorization to the patient if you request. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.

New Hampshire state law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions. Please indicate, below, the information you **do not** wish to include in this release:

□ Records of care and treatment for **HIV/AIDS**

□ Records of **Mental Health** care and treatment

□ Records of **Substance Abuse** care and treatment

___ Fax records _____
Fax number

___ Mail records _____
Mailing address

___/___/___ _____ _____
Date Signature of individual patient or representative Authority or relationship of representative

Print Submit by Email

1 Hampton Road, Suite 200 Exeter, NH 03833 (603) 775-7575 Fax- (603) 778-9680