AUTHORIZATION TO SHARE PATIENT HEALTH INFORMATION

Dr. Montanarella & Associates, PA
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PATIENT INFORMATION

Patient Name: _____ DOB: _____Phone Number: ( ) _____

Address: _____City: _____ State: _____ Zip Code:_____

RECIPIENT

I authorize Dr. Montanarella & Associates, PA to share my health information with:

Name of Person/Entity: _____ Phone Number: ( ) _____

Street Address: _____City: _____ State: _____ Zip Code:_____

Purpose/Information of the Disclosure: ( ) Transfer of Care ( ) Second Opinion ( ) Other (specify): _____

Will this information be used for marketing? ( ) Yes ( ) No Has this information been previously de-identified? ( ) Yes ( ) No

Persons Authorized to Use or Disclose the Above Information: _____
(Name of person or organization)

Persons to Whom Information May Be Disclosed:_____
(Name of person or organization)

HEALTH INFORMATION TO BE SHARED

Copies of my health information within the following dates: _____ **to** _____

( ) Full Medical Record ( ) Other: _____

Delivery Preference: ( ) Pick-Up ( ) Mail ( ) Electronic ( ) Fax (for Medical Care Purposes) – Fax Number: ( ) _____

SENSITIVE HEALTH INFORMATION

The following types of information will be released UNLESS you place your initials in the space provided:

_____ Mental health treatment records
_____ Genetic Testing
_____ HIV/AIDS test results
_____ Sexually Transmitted Diseases (STD) treatment records
_____ Alcohol/drug abuse treatment records

DURATION & REVOCATION

This authorization will remain in effect for one year from the date of the signature below, unless you specify a different date here: _____ (date). You or your Personal Representative may revoke this authorization at any time by providing written notice as specified in our Notice of Privacy Practices; however, your revocation will not apply to any previously released information.

ADDITIONAL INFORMATION

I understand that:

- A fee for the cost of processing this request will be charged*
- Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.
- Our practice will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.
- Once this information is shared with the recipient you specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations.

( ) I understand that records sent by e-mail without encryption are at risk for unauthorized access and request that my records be sent by e-mail without encryption to this address _____

*The practice reserves the right to charge up to the maximum permitted by NH State Law, which is subject to change; RSA 332-I, which allows patients to obtain a copy of their medical records for a limited charge. RSA 332-I:1, (Medical Records), states that the charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

SIGNATURE

Name of patient (Type/Print)

Signature of Patient Date

Signature of Patient Representative (if applicable) Relationship of Patient Representative to Patient (if applicable)