Seapoint Family Healthcare

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

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Phone: (603) 433-4774 Fax: (877) 795-5369

Name: _____ **Date of Birth:** _____
Phone: _____

I authorize Seapoint Family Healthcare to use/disclose my complete medical record:
Purpose of Disclosure: ☐ **Transfer of Care** ☐ **Communication with Providers** ☐ **Other** _____

☐ **Records to be *SENT* to:** ☐ **Records to be *RECEIVED* from:**
Name: _____
Address: _____
Phone: _____ **Fax:** _____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information
_____ (Initial) If not applicable, check here ☐

Disclosure to Friends and/or Family Members: (please complete if applicable)

Name	**Relationship**	**Contact Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____

*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 that information 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 of disclose your health information.
- This authorization will expire in 6 months (180 days) from the date below.
- The information may be released by any acceptable means, including fax.
- A copy of this release is as valid as an original (e.g. fax).

Signed: _____ **Date:** _____
(Patient, or if minor, parent or legal guardian)