AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

For Internal Use only:
MRN: _____
Request #: _____

Patient: _____

Date of Birth: _____

Address: _____

_____

Telephone: _____

Other names under which the Patient has been treated:

_____

I authorize _____ and its employees, agents or associated healthcare practitioners NEMHS to use or disclose the Patient's protected health information as described below.

1. **Relevant Time Period**. NEMHS may use or disclose information relating to healthcare provided during the following time period:

☐ Anytime.

☐ Healthcare provided between (*date*) _____ and (*date*) _____.

2. **Types of Information.** NEMHS may use or disclose the following type(s) of information:

☐ Any information concerning the Patient's healthcare or payment during the relevant time period.

☐ Medical records concerning the Patient's healthcare during the relevant time period, including:

☐ Records from the Patient's chart (*e.g.*, history, examination, progress notes, lab results, diagnostic test results, operative reports, discharge summaries, photographs, *etc*.)

☐ Diagnostic images, films or other recordings (*e.g.*, x-rays, MRI scans, CT scans, *etc*.)

☐ Psychotherapy notes ***[Note: These cannot be combined with authorization for other records]***

☐ Billing and payment records for healthcare rendered during the relevant time period.

☐ Sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health, and treatment for alcohol and drug abuse.

☐ Discharge Education and Aftercare for the Lay Caregiver

Other: _____

3. **Persons to Whom Disclosure Allowed.** NEMHS may disclose the information to the following entity(ies):

Name or description: _____

Address: _____

_____

Phone number: _____

Is this a Lay Caregiver? ☐ Yes ☐ No If yes, what is their relationship to the patient?

_____

4**. Purpose**. PROVIDER may use or disclose the information for the following purpose(s):

☐ The disclosure is made at the Patient's request.

☐ For a potential or pending legal proceeding.

☐ For marketing. NEMHS *will/will not (circle one)* receive remuneration form a third party for the use or disclosure of the information.

☐ Other: _____

I understand that I have the right to revoke this authorization at anytime except to the extent that NEMHS has taken action in reliance on this authorization. To revoke this authorization, I must submit a written revocation to:

NEMHS Medical Records

I understand that NEMHS may not condition the Patient's healthcare on this authorization unless (1) the purpose for NEMHS's evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, or (2) the Patient is involved in research-related treatment and the use or disclosure is for such research.

I understand that information disclosed by NEMHS pursuant to this authorization may be re-disclosed by the entity who receives this information and may no longer be protected by privacy regulations. This authorization will expire on the following date or event:
_____. If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization.

_____ _____

Signature Date

_____

Authority or relationship to the Patient

- *Give a copy of the authorization to the Patient or personal representative.*