Authorization to Disclose Protected Health Information

Bedford Commons OBGYN - 201 Riverway Place, Bedford, NH 03110
Phone: (603) 668-8400 - Fax: (603) 626-7368

Name: _____ Date of Birth: _____
Maiden Name or other name (if applicable) _____ Phone #: _____
Address: _____

I authorize Bedford Commons OB-GYN to (choose only ONE response) - *Must complete all information.*

OR ☐ **Receive Records From:**
☐ **Send Records To:**

Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Please select the information to be released:

☐ 1. PCP Package: Most recent Annual Exam, Office Notes, Pap test, Mammogram and Lab results
☐ 2. Pregnancy Package: Pregnancy ACOG Flowsheet, Lab results (including genetic testing results) Ultrasounds, Delivery Summary and Operative Report
☐ 3. Pap test only
☐ 4. Mammogram: (Please specify where it was done): _____
☐ 5. Other (Please specify): _____
_____
_____
_____

Are you transferring from our practice? ☐ Yes ☐ No

Sensitive information: I acknowledge, and hereby consent to such, that the released information may contain sexually transmitted disease (STD) testing, alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results, or AIDS information: _____ **(initial)**

By signing this authorization, I understand that:

- Bedford Commons OB-GYN will treat me even if I decline to sign this authorization.
- Upon request, I can inspect or obtain a copy of the information I am authorizing to be released. A fee for the costs of processing this request may be charged pursuant to NH State Law Chapter 332-I section 332-I:1. There is no charge for record exchanges between healthcare providers currently treating you.
- Once I authorize the disclosure of my health information, it is no longer considered protected information and re-disclosure by the recipient is legally permitted.
- I can revoke this authorization at any time by submitting a request in writing to Bedford Commons OB-GYN. This will not apply to any previously released information.
- I understand that this will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ _____ _____
Signature of Patient or Legal Representative/Guardian | Authority or Relationship of Representative (Attach copy of documentation of authority) | Date

***This authorization expires six months from that date of signature or on _____. If you would like a copy of this form, please let us know. BCOG Rep _____**