AUTHORIZATION FOR THE RELEASE OF PATIENT HEALTH INFORMATION

Patient Information

Patient Name: ____ **Date of Birth:** _______________________

Street Address: ____

City: _________________________ **State:** _____ **Zip:** ___________ **Phone Number:** (___) ___-___________

Facility Information

Please check the current location of the records you want shared:

☐ **Bedford Ambulatory Surgical Center**, 11 Washington Place, Bedford, New Hampshire 03110

☐ **BASC Imaging**, 20 Washington Place, Bedford, New Hampshire 03110

Recipient

I authorize the release of my health information to:

Name of Person/Entity: ____

Title (Physician, Attorney, Etc.): ____

Street Address: ____

City: _________________________ **State:** _____ **Zip:** ___________ **Phone Number:** (___) ___-_____________

Purpose of Disclosure:

☐ **Medical Care** ☐ **Insurance** ☐ **Legal** ☐ **Workers' Compensation**

☐ **Other (please specify):** ____

Health Information To Be Shared

I authorize and request the designated record custodian of the Facility or Facilities identified above to disclose the following health information:

☐ **Complete Patient Records.**

☐ **Specific Medical Records.** Check all that apply:

☐ **Lab/Pathology Records.** All laboratory, pathology, and immunization records.

☐ **Radiology Records.** All radiology records, including CT scan, MRI, MRA, EMG, bone scan, myleogram, echocardiogram, and cardiac catheterization reports and images.

☐ **Pharmacy Records.** Copies of presriptions.

☐ **Billing Records.** All billing records, including statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period ____________ to ____________.

Sensitive Health Information

The following types of information will be released UNLESS you check the box to decline authorization to release the information:

☐ Mental Health Treatment Records **☐ HIV/AIDS Test Results** **☐ Genetic Testing**

☐ Sexually Transmitted Disease (STD) Treatment Records **☐ Alcohol/Drug Abuse Treatment Records**

Duration and Revocation of Authorization

This Authorization for the Release of Patient Health Information expires in twelve (12) months, unless a different date is specified here: ___________ (date).

You or your Personal Representative may revoke this authorization at any time by providing written notice to: Bedford Ambulatory Surgical Center, LLC, Attention: Privacy Officer, 11 Washington Place, Bedford, New Hampshire 03110. Your revocation will not apply to any previously released information.

Additional Information

I understand that:

- A fee for the cost of processing this request may be charged.
- Neither the Bedford Ambulatory Surgical Center nor BASC Imaging will condition my ability to receive healthcare services on providing or refusing to provide this authorization.
- Once this information is shared with the recipient, how that recipient further discloses it may no longer be protected under federal and state privacy regulations.
- If I am requesting medical records for someone other than myself, I may be required to provide additional documentation to show that you have a legal right to request the record set. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavits of Heirs at Law, etc.

Signature

____	_________________________________
Signature of Patient or Personal Representative	Date
____	_________________________________
Printed Name of Patient or Personal Representative	Description of Personal Representative's Authority