

TERM: This Authorization will remain in effect (please check one)

- From the date of this Authorization until the _____ day of _____ 20_____
- Until One Year (1) from the date signed

PURPOSE: I authorize **DMC/LFPC** to use and disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s):

- | | |
|---|--|
| <input type="checkbox"/> Transferring Out of Practice | <input type="checkbox"/> Personal Use |
| <input type="checkbox"/> Continuing Medical Care | <input type="checkbox"/> Attorney/Legal Case |
| <input type="checkbox"/> Insurance/Disability | |

I understand that I may inspect or obtain a copy of the protected health information described by this authorization.

I understand that DMC/LFPC will not condition treatment, payment or (if applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure and that I may refuse to sign this authorization.

I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of DMC/LFPC. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Requests for access to and copies of your medical information must be submitted to Derry Medical Center by completing and signing this form.

**** If you're transferring out of our practice, the 1st Copy released is FREE. For additional copies the practice charges a \$15.00 for the first 30 pages and .50 for each additional page. The fee for any records to be copied from an outside facility will be 50 cents per page.****

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of health information. By signing my name below, I hereby, knowingly and voluntarily authorize DMC/LFPC to use and disclose my PHI in the manner described above:

Signature Of Patient **Date**

If the patient is a minor or is otherwise unable to sign this Authorization, the signature of a parent, guardian or other legal representative is required:

Signature of Personal Representative **Date**

Print Name **Relationship To Patient**

COPY PROVIDED: DMC/LFPC shall provide a copy of this signed authorization to the patient if you request. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.

New Hampshire state law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions.