Bedford Commons OB-GYN, PA
201 Riverway Place, Bedford, NH 03110
Phone #: 603-668-8400 Fax #: 603-626-7368
Authorization to Disclose Protected Health Information
Records Release of Information

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

I authorize Bedford Commons OB-GYN to:
☐ **Send Records to:**
☐ **Retrieve Records from:**

Practice Name: _____ **Phone #:**_____
Physician Name: _____ **Fax #:** _____
Address: _____

If records are to be released to patient: please indicate method of delivery below: ☐ **Pt to pick up records**
☐ **Via Secure Email Address**_____ ☐ **Patients Fax #** _____ ☐ **Mailing Address**_____

For the following purpose(s):

☐ Transfer of care ☐ Concurrent care ☐ Personal records ☐ Other: (Legal/Ins) _____

Type of information requested:

Please select a package:

☐ **PCP Package:** Most recent Annual Exam, Office Notes, Pap, Mammogram and Lab Results

☐ **Pregnancy Package:** _____ (Specify Year) ACOG Flowsheet, Ultrasounds and Operative Report/Delivery Summary

Or select specifically what you'd like us to send:

☐ Office Notes_____ _____ ☐ Operative Reports _____ _____ ☐ Mammogram _____
Date **Specify** **Date** **Specify** **Dtae**

☐ Lab Results _____ _____ ☐ Pap Smear _____ ☐ Dexa Scan _____
Date Specify Date Date

☐ Imaging _____ _____ ☐ Other _____
Date Specify Type
Please select one → ☐ Report ☐ Images on Disk
(If not specified, Report will be assumed)

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.

- **The following types of information WILL BE INCLUDED UNLESS indicated by you initialing below:**

Drug and/or alcohol treatment:	**Initials: _____**	**Psychiatric:**	**Initials: _____**
Sexually transmitted disease:	**Initials: _____**	**Genetic testing:**	**Initials: _____**
HIV (AIDS) testing/treatment:	**Initials: _____**		

This authorization expires six months from the date of signature, or on:_____
I have been offered a copy of this form.

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

Must be completed by Bedford Commons OB-GYN staff:

Date received:_____ Date completed:_____
Request completed by:_____(Name)
Delivery method: □ In Person □ Mail □ Fax Initials of requesting provider:_____

Rev. 03/14/2018 pb