# Authorization For Use or Disclosure of Medical Record Information

## Seacoast Pain Institute of New England

**C/O Sharecare HDS**
**100 Cummings Center Drive Suite 351G**
**Beverly, MA 01915**

### Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State _____ Zip: _____ Work Phone: _____

### I hereby Authorize

**Please choose one:** ◉ Release my medical record information to ○ Obtain information from

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ○ Personal ○ Referral or 2nd Opinion ○ Legal ○ Insurance ○ Other _____

○ Transfer from Practice/Reason? Closure of the site .

### Information to be Released

○ Please provide a two year abstract of my medical record.

○ Please provide the information as outlined in the comments box to the right.

*Comments*

**Fee:**

The fee for this abstract is $ 15.00 if going to the patient or another provider. Please submit this fee in advance with this authorization. Your copy will be produced and fulfilled within 10 business days of receipt of this authorization and your payment. If the copy is for a 3rd party, the fee will be in accordance with NH Statute. (Flat fee of $15 to include up to 30 pages, over 30 pages are $.50 a page)

### Authorization to Release Protected Information

*__Required__ - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

*Release Records? Check one*

I ■ DO ☐ **DO NOT** want **Mental Health or Psychotherapy Notes/Information** released
I ■ DO ☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released
I ■ DO ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released
I ■ DO ☐ **DO NOT** want information about ***Genetic Testing** released
I ■ DO ☐ **DO NOT** want information about **Social Worker Communication** released
I ■ DO ☐ **DO NOT** want information about **Rape/Sexual Abuse** released
I ■ DO ☐ **DO NOT** want information about **Developmental Disability** released
I ■ DO ☐ **DO NOT** want information about **Sexually Transmitted Disease (STD's)** released
I ☐ DO ☐ **DO NOT** want information about _____ released

*Other sensitive information?*

STOP Please confirm that you have put a checkmark by **all** the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Sign Here Date Here

**Patient's Signature** **Date***

**Parent/Legally Recognized Representative Signature**** **Date****

**Know Your Privacy Rights Refer to the HIPAA "PRIVACY NOTICE"**

Rev. 10/19

*This Authorization is valid for one year unless you specify other wise (enter expiration date)_____. You may revoke this Authorization at any time by providing a written statement, except to the extent that Seacoast Pain of New England has already completed action on it.

*The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem.

** If you are the legally recognized represenatative of the patient you must provide supporting documentation.

The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. Seacoast Pain of New England will not condition treatment on payment of the provision of this Authorization.