University of New Hampshire
Health & Wellness

Form #201.1

AUTHORIZATION TO RELEASE OR REQUEST HEALTH INFORMATION

Health Records Department
603-862-0832/Fax 603-862-4259

4 Pettee Brook Lane
Durham, NH 03824-3577

Patient's name:_____ Date of birth:_____

Address:_____City:_____State:_____Zip:_____

Patient's Student ID #:_____ Phone:_____

I request that my protected health information (PHI) be: ☐Released To: ☐ Obtained From:

Name:_____ Phone:_____ Fax _____

Address:_____City:_____State:_____Zip:_____

Information to be disclosed/obtained includes the period of health care:

From (date)_____**To** (date)_____

***Note**: Dates can not be in the future. The date of signature below must be the same as or later than the date of information to be released.

I authorize the following PHI to be released:

☐Visit notes ☐X-ray reports ☐History & physical exam ☐Immunization
☐Laboratory tests ☐Complete Health Record ☐Other: _____

Purpose for Release of information: ☐Continuation of care ☐Legal ☐Insurance ☐Personal

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Drug/Alcohol/Substance Abuse:	☐Yes	☐No	Dates:_____
Mental Health:	☐Yes	☐No	Dates:_____
HIV testing results:	☐Yes	☐No	Dates:_____
Genetic Records:	☐Yes	☐No	Dates:_____

I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken in response to this authorization. I also release UNH Health & Wellness from any liability or legal responsibility in connection with the release of the above information. I understand the information disclosed pursuant to this authorization is subject to re-disclosure by the recipient (other than UNH Health & Wellness), which would be beyond the control of UNH Health & Wellness, and may no longer be protected by federal law. Requests for copies of health records are subject to reproduction fees in accordance with state & federal regulations.

By signing below, I accept the risks and potential consequences of having my protected health information faxed.

Type of request: ☐Mail directly to UNH Health & Wellness, Attention Health Records
☐For pickup
☐Mail to patient
☐Mail to addressee above
☐Verbal

_____ _____ _____
Patient Signature Date Witness Signature

UNH Health & Wellness does not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization or not. **This authorization is valid for 90 days.**

(Sept2018) *Date Received*_____ *Health Record #*_____