CORE PHYSICIANS
an exeter health resource | The Art of Wellness

Medical Records Authorization to Request and or Release Health Information

Release Medical Records

☐ I authorize Core Physicians. LLC (Core) to **release** the protected health information from the medical record of:

Last Name	First Name	MI	Date of Birth	
To: Practice Name	Mailing Address	City	State	Zip Code

Request Medical Records

☐ I authorize Core Physicians. LLC (Core) to **request** the protected health information from the medical record of:

Last Name	First Name	MI	Date of Birth		
From: Practice Name	Mailing Address	City	State	Zip Code	Fax Number
To: Practice Name	Mailing Address	City	State	Zip Code	Fax Number

Term:

This authorization will remain in effect:

☐ From the date of this authorization until the _____ day of _____, 20_____.

☐ Until the following event occurs: _____

☐ Other: _____

So that we may improve our patient care, please let us know the reason you are requesting this record release: *Please check all that apply.*

☐ Second Opinion
☐ Moving to another location
☐ Other, please describe:
☐ Dissatisfied with Provider
☐ Change of Health Insurance

Type of information to be disclosed: *Please check below and unless specified, most recent date will be released.*

☐ History & Physical
☐ Discharge Summary
☐ Consultation Report
☐ Operative Report
☐ Laboratory Reports
☐ Imaging *(x-rays, CT scans)*
☐ Other, *please describe*:
☐ Emergency Room
☐ Progress Note
☐ Orders
☐ PT/OT, Respiratory, Dietary Notes
☐ Nursing Notes and forms
☐ Medication Record

I understand that the information in my medical record may include information relating to sexually transmitted disease, AIDS, and/or HIV. It may also include information about behavioral or mental health services and/or alcohol and drug abuse treatment. I agree to its release:

Information about a Mental Illness or Developmental Disability	*Initial Yes or No*	☐	**Yes**	☐	**No**
Genetic Testing	*Initial Yes or No*	☐	**Yes**	☐	**No**
Information about Venereal Disease(s)	*Initial Yes or No*	☐	**Yes**	☐	**No**
Social Service Information (e.g., child abuse and neglect, domestic abuse of an adult with a disability, sexual assault)	*Initial Yes or No*	☐	**Yes**	☐	**No**
Substance Abuse/Treatment (drug / Alcohol)	*Initial Yes or No*	☐	**Yes**	☐	**No**
HIV/AIDS Information (Including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)	*Initial Yes or No*	☐	**Yes**	☐	**No**

I understand that once Core discloses my health information to the recipient, it cannot guarantee that the recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of Core treatment of me; except, however, if my treatment at Core is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Core may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Core at the address listed below. The revocation will be effective immediately upon Core's receipt of my written notice, except that the revocation will not have any effect on any action taken by Core in reliance on this Authorization before it received my written notice of revocation.

I may contact the Privacy Officer by mail at: Core Physicians, LLC 7 Holland Way, Exeter, NH 03833.

Signature of Patient or Legal Representative* *When applicable, attach legal documents	Date	Relationship, if other than patient
Signature of Witness	Date	

Please Note: There may be a charge for the copying and mailing of medical record copies.

Office Use Only:

Patient Phone Number: _____

❑ Patient Pick Up
❑ Mail to Patient

ID Verified? ❑ Yes ❑ No