Manchester Urology Associates, PA
Dover Manchester Derry
PERMISSION TO RELEASE OF HEALTHCARE INFORMATION

PATIENT INFORMATION – REQUIRED:
Name: ____
Date of Birth: Month _______________ **Day** _________________ **Year** ____________________
Address: ____
Telephone: Home: ____________________________ **Cell:** _______________________________________

IMPORTANT: Manchester Urology utilizes CIOX to process their Medical Records. **You will incur a change for your Medical Records except for Medical Records that are sent directly to another Physician for continuity of your medical care. All requesters other than direct release to a Physician's Office will be billed at the New Hampshire State fee schedule allowed.**

I AUTHORIZE TO RELEASE INFORMATION TO:
NAME, PHYSICIAN, OR INSURANCE: ____
Full Address: ____
State: ___________**ZIP Code:** _______________**FAX NUMBER:** ____________________________________

ALL MEDICAL RECORDS REQUESTED WILL BE MAILED TO INFORMATION INDICATED ABOVE:

_______ FAX TO NUMBER **FOR PHYSICIAN OFFICES ONLY** _______ MAIL TO ADDRESS INDICATED ABOVE

PATIENT INFORMATION TO BE RELEASED: You must check all type of medical records you are requesting
__Office Notes/Progress Notes __Operative Notes __Discharge Summary __ Lab __ X-Ray
Complete Medical Record for indicate number of years prior ____
DATES OF SERVICE TO BE RELEASED: FROM: ____________________ TO: _____________________

SENSITIVE INFORMATION: If the information to be disclosed contains any of the following types of information listed below, additional laws and/or signature requirements may apply. **I understand and agree that this information will be sent UNLESS I place my initials in the applicable space next to the type of medical record.**
___Mental Health ___Alcohol and Drug Treatment ___Sexually Transmitted Disease ___HIV ___Genetic Testing

PURPOSE FOR WHICH THIS INFORMATION IS BEING RELEASED: Please check all that applies
___ Continued Medical Care ___ Insurance ___ Life Insurance ___ Inspect records on site
___ Legal ___ Personal ___ Transfer to Another Physician ___ Consultation with Specialist

FAX RELEASE NOTICE: I am aware that the above requested information is to be released via a fax machine. I am also aware of the risks associated with faxing protected health information and sensitive health information, including but not limited to: erroneous transmission, lack of confidentiality safeguards at the site of the receiving machine and incomplete transmission information.

I UNDERSTAND: The information released is confidential and must be used for the purpose that it was requested for; however, once the information is disclosed, the information may be subject to re-disclosure and may no longer be protected by Federal and State confidentiality laws. I may revoke this authorization at any time IN WRITING, provided the information has not already been disclosed in reliance on this authorization. Additional details may be found at manchesterurology.com. I know that this authorization is voluntary, and I may refuse to sign this form. I understand that refusing to sign this form will not affect my ability to obtain treatment from Manchester Urology Associates, PA.

I have read this entire form or have had it read to me. I understand the content. I hereby authorize the release of my patient information stated above and release Manchester Urology Associates, PA from any legal responsibility or liability relating to the release of information. This authorization will remain in effect and valid for a period of one year only from the date of signature unless you specify a different date less than one year here _______________________________.

SIGNED:____
Patient/Parent/Legal Agent Signature **Date**