Further Care Psychiatric Services
Psychiatric Care For Northern New England
20 Ladd St 4TH Floor • Portsmouth, NH 03801 • Phone: (603)294-4424 • Fax: (603)319-1603

Authorization for Release of Protected Health Information

Full Legal Name: _____ DOB: _____ (MM/DD/YYYY)

Current Address: _____ (Street / City / State / Zip Code)

Telephone #: _____ (Home) _____ (Work) _____ (Cell)

I hereby authorize the following Health Care Provider to disclose the protected health information from the medical records of the individual listed above: FURTHER CARE PA (Name of Health Care Provider)

Information is to be RELEASED to:

Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

DISCLOSE THE FOLLOWING INFORMATION FOR THE PAST TWO (2) CALENDAR YEARS:

☐ Complete Records ☐ Other: _____

PURPOSE OF DISCLOSURE: _____

Please read the following statements **CAREFULLY:**

1) A Photocopy or fax of this authorization shall be as valid as the original.
2) This Authorization for Disclosure of Protected Health Information is not a required condition for treatment.
3) If the person(s) or organizations(s) authorized to receive the information is not a health plan or health care provider, the disclosed information may be re-disclosed and would no longer be protected by federal privacy regulations.
4) Information disclosed may include psychiatric, substance abuse, HIV infection, AIDS, or tests for HIV.
5) Medical information may be disclosed via fax machine unless otherwise specified.
6) This authorization may be revoked at any time.
7) I am entitled to a copy of this authorization after I sign it.

REVOCATION: I understand that I may revoke this authorization by notifying Further Care PA in writing, to the above-noted address, at any time, except to the extent that the authorization has already been used to request information prior to my revocation.

EXPIRATION: This authorization will expire 12 months from the date it was signed.

_____ Signature of Applicant or Legal Representative

_____ Signature of Witness

_____ Date

Authority of representative: ☐ Parent of minor ☐ Guardian ☐ Other:_____

NOTE: Copies of applicable documentation for the representative's authority MUST be attached.

A PHOTOCOPY OF THIS AUTHORIZATION WILL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL

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New Hampshire Law

STATE LAW, RSA 332-I, allows patients to obtain a copy of their medical records for a limited charge. RSA 332-I states the following:

"**332-I:1 Medical Records. –** All medical information contained in the medical records in the possession of any health care provider shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost."

After completing the above release, please mail to Further Care with a copy of photo identification. You will be contacted for payment after calculating the total invoice.

Postage charges are additional.

You may fill out the credit card authorization below if you choose; however, be aware that the final charge cannot be calculated until the request is received. Alternatively, we will contact you with the total amount due.

You may estimate the total charge by taking the number of appointments multiplied by 10 multiplied by $0.50. Then add $15 for postage. Please note we will only charge the correct amount and will provide an invoice upon request.

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Single Credit Card Payment Authorization Form

Sign and complete this form to authorize Further Care P.A. to make a single debit to your credit card listed below.

By signing this form you give us permission to debit your account for the up to the maximum amount indicated. This is permission for a single transaction.

Please complete the information below:

I _____ authorize Further Care P.A. to make a
Repsonsible Party Full Name

single charge to the account indicated below for up to $100.00.

This payment is for the estimated balance due to Further Care P.A for medical records and postage.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE _____ DATE _____

I authorize Further Care P.A. to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services described above, for the amount indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.