Families First Health & Support Center • 100 Campus Drive, Suite 12 • Portsmouth, NH 03801
Tel: 603-422-8208 Fax: 603-422-8218

Authorization to Verbally Discuss Protected Health Information (PHI)

Patient Name: ______________________________ Date of Birth: ______________

Phone #: ______________ Email: ______________________________

I authorize Families First to discuss the contents of my medical record with:

Name: ______________________________ Phone: ______________

Medical Information to be Discussed:

❒ Medical visits ❒ Dental visits ❒ Labs ❒ Hospital Records ❒ Imaging Reports

❒ Other:______________________________

I UNDERSTAND THAT THE RECIPIENT OF THIS INFORMATION MAY RE-DISCLOSE THIS INFORMATION.

I UNDERSTAND THAT MY BASIC MEDICAL AND/OR DENTAL OFFICE NOTES MAY CONTAIN INFORMATION THAT REFER TO SOME OF THE SENSITIVE INFORMATION LISTED BELOW.

Sensitive Information to be Released:

IMPORTANT - It is extremely important that you check DO or DO NOT for each item listed below. Please do not skip any item as it could impact our ability to fulfill your request and cause additional delays.

Allow Discussion? Check one box in each row:

I ❒ DO ❒ DO NOT want detailed Behavioral/Mental Health records discussed
I ❒ DO ❒ DO NOT want detailed HIV/Aids/Sexually Transmitted Disease records discussed
I ❒ DO ❒ DO NOT want detailed Alcohol/Substance Abuse records discussed
I ❒ DO ❒ DO NOT want detailed Genetic information discussed
I ❒ DO ❒ DO NOT want detailed Prenatal records discussed
I ❒ DO ❒ DO NOT want detailed Home Visiting records discussed

To the recipient: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless it is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Authorization

This authorization is valid for **one year** and may be revoked at any time in writing prior to the expiration date, except to the extent Families First has already used or disclosed the information in reliance on my authorization.

______________________________ ______________________ ____________
Signature of Patient or Personal Representative Relationship (if not patient) Date