New England Heart & Vascular Institute

Patient Name:______________________ MRN:__________________

Date of Birth: ______________ Tel. No: ____________________________

Please check one of the following:

Option A

☐ I wish to continue care with Dr. Young and transfer my medical records to St. Joes Nashua. I understand this would mean completely transferring my vascular care to SJH and any office visits, imaging, testing and procedures will be done at SJH unless otherwise arranged by my provider.

Option B

☐ I wish to transfer care to a different provider at VAVS Bedford. Please assign me a new provider in the Bedford office. I understand all further office visits, imaging, testing and procedures will occur at CMC unless otherwise arranged by my provider.

______________________________ ______________________________

Patient Name (Print) Relationship of Rep., if applicable

______________________________ ___/___/___ ____:____

Signature (of Patient or Legal Guardian) Date Time

If you chose option A please fill out the next form. If you chose option B you may forgo the next form and return this packet to VAVS via the included envelope.

AUTHORIZATION TO RELEASE OR REQUEST PROTECTED HEALTH INFORMATION

Please Check One:
☐ Pick Up: __ Paper Copy __ eCopy
☐ Mail
☐ Fax (to other Providers only): __________

Patient Name: ______________________________ Date of Birth: ______________________________

Address: ______________________________ Tel. No: ______________________________

AUTHORIZATION TO: (Check One)

☐ *Release* Patient Information to: St. Joseph Hospital
Street: 172 Kinsley Street City/State: Nashua, NH 03060

☐ *Request* Patient Information from: Catholic Medical Center Vein and Vascular Specialists
Street: 160 S River Rd., Suite 100 City/State: Bedford, NH 03110

DATES OF SERVICE for patient information to be released or received: Start of chart to Present.

PATIENT INFORMATION to be released or received: (Check All That Apply)

☐ ED Visit ☐ Cardiac Testing ☐ Laboratory Tests ☐ Medical Images (report only) ☐ Office Notes
☐ Abstract (Discharge, Summary, History & Physical, Procedures, Consults, plus the above items).
☐ Other: (Please Specify) ______________________________

SENSITIVE INFORMATION: (Please Initial)
Behavioral Health _____ HIV/AIDS _____ Drug or Alcohol* _____ Genetic Testing Results _____

PURPOSE for which this patient information is being requested/ released: (Check One)
☐ Continued Medical Care ☐ Transferring Out of Practice ☐ Other: (Please Specify) ______________

- I understand that I may inspect or obtain a copy of the protected health information described by this Authorization.
- I understand that Catholic Medical Center shall not condition treatment on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.
- I understand that this Authorization may be revoked in writing and the written revocation must be delivered to the Medical Records Department, revocation will not be effective for the disclosure of records whose release I had previously authorized, or where other action had been taken in reliance on a valid authorization.
- I understand that information used or disclosed pursuant to this Authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- I understand that it is my sole responsibility to safeguard any of my protected health information provided to me directly, and that Catholic Medical Center has not encrypted or otherwise protected any electronic media provided to me with my health information and shall not be liable for any subsequent acquisition, access, use or disclosure.

EXPIRATION DATE: This Authorization is valid until: (Insert date/event no later than one year from now) ________
(If no date/event is stated, this Authorization expires one year from the date it was signed.)

___/___/___ ____:____ ______________________________ ______________________________
Date Time Signature of Patient or Representative Relationship of Representative, if applicable

☐ COPY PROVIDED: If requested, CMC shall provide a copy of this signed Authorization to the subject individual.

* This information has been disclosed to you from records whose confidentiality is protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclose of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any Alcohol or Drug abuse patient. (42 C.F.R. §2.32)