convenientMD
360 US-1 Bypass, #102. Portsmouth, NH 03801

Permission to Request Patient Health Information:
Patient Info

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone Number: _____
Email: _____

I authorize ConvenientMD Primary Care to request my health information from the following entities:

Office Name: _____ Provider Name: _____
Street Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

Office Name: _____ Provider Name: _____
Street Address: _____ Phone: _____
City: _____ State: _____ Zip: _____
**To add additional providers to request information please see page 2.*

Purpose of Disclosure:
____Medical Care ____Legal Transferring to a new provider
____Insurance ____Other_____

Select from the below list the health information that is to be shared:
____ **All information may be shared**
____Abstract **(cover page of any medical reports)**
____Immunizations
____Discharge summary
____Operative reports
____Inpatient progress notes
____X-ray reports
____X-ray films
____Outpatient visit (office) notes
____Emergency department reports
____Laboratory/pathology reports
____School physical forms
____Other_____
____Records from a specific provider:
_____

Sensitive Health Information:
The following types of information **WILL BE** requested to be released from your current provider to ConvenientMD **UNLESS** you place you initials in the space provided.

____Mental Health Treatment Records
____Genetic Testing
____Alcohol/Drug abuse treatment records including addiction treatments
____Sexually Transmitted Disease Treatment Records
____HIV/AIDS test results

Duration & Revocation: You or your personal representative may revoke this authorization at any time by providing written notice to ConvenientMD by contacting the Data Privacy Officer as provided below. However, your revocation will not affect any prior use or disclosure made by ConvenientMD in reliance on this authorization before the revocation.
Unless terminated sooner by you, this authorization will expire when you are no longer a patient of ConvenientMD.

Data Privacy Officer: Phone: 603-319-4529 **Email:** DataPrivacy@convenientmd.com **Address:** 360 US-1 Bypass, #102, Portsmouth, NH 03801

By signing this form, I understand that if my health information is released pursuant to this authorization, it may further be re-disclosed by the recipient and may no longer be protected under the terms of the HIPAA privacy rule. Additionally, I understand that the failure to sign/submit this authorization or the cancellation or revocation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

_____ _____
Signature of Patient or Responsible Party **Date**

_____ _____
Printed Name of Patient or Responsible Party **Date**

Office Name: _____ Provider Name: _____
Street Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

Office Name: _____ Provider Name: _____
Street Address: _____ Phone: _____
City: _____ State: _____ Zip: _____