AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name _____ Date of Birth _____

Patient Address _____

Patient Phone _____

I authorize NH Eye Associates to release/receive health information identifying me (including, if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS):

☐ Receive health information from: **OR** ☐ Release health information to:

Name of provider or facility _____

_____
Street address, City, State, Zip

( ) _____ ( ) _____
Phone Number Fax Number

PLEASE FAX RECORDS (FOR CONTINUITY OF CARE) TO: NH EYE ASSOCIATES Fax 603-669-0380

It is completely your decision whether or not to sign this form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting the Administrator in writing.

When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

☐ **I HAVE READ AND UNDERSTAND THIS FORM**. ***THERE WILL BE A $15.00 FEE FOR MEDICAL RECORDS RELEASED TO PATIENTS.***

_____ _____
Patient signature Date

If you are signing as a legal representative of the patient, please indicate your relationship

_____ _____
Legal Representative Relationship to Patient

1415 Elm Street • Manchester, NH 03101 • 603-669-3925 • Fax 603-669-0380
25 Buttrick Rd, Ste. C3 • Londonderry, NH 03053 • 603-432-8801 • Fax 603-432-8806