

764 Second St • Manchester, NH 03102 • 603-669-3925 • Fax 603-669-0380

25 Buttrick Rd, Ste. C3 • Londonderry, NH 03053 • 603-432-8801 • Fax 603-432-8806

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Patient Name Date of Birth

Patient Address

Patient Phone

Authorization to (*check one*): □ Receive health information from: **OR**  □ Release health information to:

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

Name of provider, patient, or facility:

Street address, City, State, Zip

( ) ( )

Phone Number Fax Number

Personal Copy: □ Pick Up in Office □ Mail to patients home

**DATES OF SERVICE** for patient information to be released or received: \_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT INFORMATION to be released or received: (*check all that apply*)**

□ Office Notes □ Medical images □ Laboratory Tests □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PURPOSE** for which this information is being requested/released: (*check one*)

□ Continued Medical Care □ Transferring out of practice □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I understand that NH Eye Associates 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 Practice Administrator of NH Eye Associates, 764 2nd Street, Manchester, NH 03102.
* 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 there may be **$15 fee for a personal copy** of my medical records.

**EXPIRATION DATE**: this authorization is valid until: (insert date/event) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If no date/event is stated, this authorization expires one year from the date it was signed)

Patient signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Representative Relationship to Patient, if applicable

□ PAID $15 personal copy fee