

**RELEASE OF/REQUEST FOR HEALTHCARE INFORMATION**
**PATIENT INFORMATION:**

 NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
 STREET ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

 RELEASE: TO  FROM 

Wright &amp; Associates Family Healthcare, PLLC , Liberty Park, Unit 9, 282 Route 101, Amherst, NH 03110

 RELEASE: TO  FROM 

 PRACTICE NAME: \_\_\_\_\_  
 STREET ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 PHONE: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_

**INFORMATION TO BE RELEASED: (Check all that apply)**

ENTIRE RECORD	<input type="checkbox"/>	ER NOTES	<input type="checkbox"/>
CONSULT	<input type="checkbox"/>	X-RAY/MRI/CT/ULTRASOUND	<input type="checkbox"/>
LABS/PATHOLOGY	<input type="checkbox"/>	HISTORY & PHYSICAL	<input type="checkbox"/>
OPERATION REPORT	<input type="checkbox"/>	DISCHARGE SUMMARY	<input type="checkbox"/>
EKG	<input type="checkbox"/>	OFFICE NOTES	<input type="checkbox"/>
OTHER	<input type="checkbox"/>	OTHER	<input type="checkbox"/>

**INCLUDING SENSITIVE INFORMATION: (\*Required to be checked off individually in order to be released\*)**

MENTAL HEALTH	<input type="checkbox"/>
ALCOHOL/DRUG USE/TREATMENT	<input type="checkbox"/>
HIV DIAGNOSIS / TREATMENT	<input type="checkbox"/>

**DATES OF SERVICE TO BE RELEASED:**

ALL	<input type="checkbox"/>	MOST RECENT	<input type="checkbox"/>
PAST 5 YEARS	<input type="checkbox"/>	FROM TO	<input type="checkbox"/>

**HOW TO BE RELEASED:**

PICKED UP	<input type="checkbox"/>	MAILED	<input type="checkbox"/>
FAXED (Read Release Below)	<input type="checkbox"/>	DVD (Read Release Below)	<input type="checkbox"/>

I am aware that the above requested information is to be released via a fax machine/CD/DVD. I am also aware of the risks associated with faxing or mailing protected/sensitive health information including but not limited to: erroneous transmission, lack of confidentiality safeguarding at the site of receipt and incomplete transmission of information.

**PURPOSE OF REQUEST:**

NEW PCP	<input type="checkbox"/>	CONTINUED CARE	<input type="checkbox"/>
LEGAL	<input type="checkbox"/>	INSURANCE	<input type="checkbox"/>
PERSONAL	<input type="checkbox"/>	WORK	<input type="checkbox"/>
AUTO	<input type="checkbox"/>	OTHER	<input type="checkbox"/>

**UNDERSTANDINGS:**

I understand that the information released is confidential and must be used for the purpose that it was requested for; however, once this information is disclosed, the information is subject to re-disclosure and may no longer be protected by federal privacy regulations. I may revoke this authorization at any time in writing or verbally, if followed by written confirmation. There may be an administrative fee of \$15.00 for the first 1-30 pages and 50 cents per page thereafter. I have read or have had this entire form read to me. I understand the content. I hereby authorize the release of my Private Health Information stated above and excuse the releasing party from any legal responsibility or liability relating to the release of information. This authorization is considered valid for a period of ninety days from the date of signature. The date of authorization may not precede the date(s) of service(s) being requested.

\_\_\_\_\_  
 Patient/Parent/Legal Agent Signature Date 20\_\_\_\_\_

\_\_\_\_\_  
 Relationship - Please Provide Legal Documentation if Necessary