WRIGHT & ASSOCIATES
FAMILY HEALTHCARE
AFFILIATE OF DMC PRIMARY CARE

Liberty Park
Unit 9
282 Route 101
Amherst, NH 03031
Phone: 603. 249.8883
Fax: 603. 249.1107

RELEASE OF/REQUEST FOR HEALTHCARE INFORMATION

PATIENT INFORMATION:

NAME: _____ _____ DATE OF BIRTH:_____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ PHONE: (____) _____

RELEASE: TO ☐ FROM ☐

Wright & 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	☐	ER NOTES	☐
CONSULT	☐	X-RAY/MRI/CT/ULTRASOUND	☐
LABS/PATHOLOGY	☐	HISTORY & PHYSICAL	☐
OPERATION REPORT	☐	DISCHARGE SUMMARY	☐
EKG	☐	OFFICE NOTES	☐
OTHER	☐	OTHER	☐

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

MENTAL HEALTH	☐
ALCOHOL/DRUG USE/TREATMENT	☐
HIV DIAGNOSIS / TREATMENT	☐

DATES OF SERVICE TO BE RELEASED:

ALL	☐	MOST RECENT	☐
PAST 5 YEARS	☐	FROM TO	☐

HOW TO BE RELEASED:

PICKED UP	☐	MAILED	☐
FAXED (Read Release Below)	☐	DVD (Read Release Below)	☐

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	☐	CONTINUED CARE	☐
LEGAL	☐	INSURANCE	☐
PERSONAL	☐	WORK	☐
AUTO	☐	OTHER	☐

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.

_____ _____ **20**_____
Patient/Parent/Legal Agent Signature Date

_____
Relationship - Please Provide Legal Documentation if Necessary