Northeast Integrative Medicine, LLC
Medical Records Office
72 S River Rd Ste 102 Bedford, NH 03110
Ph: (603) 647-0600 F: 603) 647-0633

OFFICE ONLY: **Date Rec'd:** ___/___/___
Date Sent: ___/___/___
Doctor: ____________________ Initials: _____

Authorization to Release Confidential Health Information

I hereby authorize:

☐ Northeast Integrative Medicine, LLC
☐ Facility/Doctor's Name: ______________________________
Address: ______________________________
City: ____________ State: ________ Zip: ____________
Phone: ______________ Fax: ______________

To release:

☐ Complete Chart Record *(does not include billing information or radiographic images)*
☐ Chart Notes ☐ All ☐ Specify: ______________________
☐ Labs/Reports ☐ All ☐ Specify: ______________________
☐ Billing Records ☐ All ☐ Specify: ______________________
☐ X-Rays/Radiographic images (specify): ______________________
☐ Other: ______________________

From the health records of:

Name: ______________________ Date of birth: ___/___/____
Soc. Sec. Number: _____-____-______ Daytime phone: ______________ ext. ___

Are you authorizing the release of your own records? ☐ Yes ☐ No
If not, what is your relationship to the patient? ______________________

Release of certain health information requires a minor's consent. The applies to persons aged 13-17 for information pertaining to substance abuse and mental health information, or persons aged 14 to 17 for information pertaining to sexually transmitted diseases, HIV, and AIDS. Other laws may apply.

To be released to:

☐ Northeast Integrative Medicine, LLC ☐ Self (please provide current address below)
^**fee may apply**

☐ Facility/Doctor's Name: ______________________________
Address: ______________________________
City: ____________ State: ________ Zip: ____________
Phone: ______________ Fax: ______________

For the purpose of:

☐ Adjunctive/Concurrent Care ☐ Transfer of Care ☐ Other: ______________

I understand that unless revoked this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.

Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis, and treatment information related to:

(check the accompanying box(es) to EXCLUDE information from authorization)

☐ Substance Abuse ☐ Mental health conditions/psychotherapy ☐ Sexually transmitted illnesses ☐ HIV/AIDS

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise specified by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected.

I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of his authorization form at the time of signing. I may call the medical records office at (603) 647-0600 to inquire about revoking authorization.

<u>I understand that if I request records for my personal use, to hand-carry to another health care provider, or for parties not involved in my health care, there may be a charge</u>. Non-emergency release of records may take up to 15 working days. Emergency requests will be given priority processing. "Emergency" status applies only to release of records directly to another healthcare provider for urgent patient care.

Patient's Signature: ______________________________ **Date:** ___/___/___

Rep/Guardian's Signature: ______________________________ **Date:** ___/___/___