

**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) **for date(s) of care:**

□ 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 MEDICAL RECORDS (FOR CONTINUITY OF CARE) TO: NH EYE ASSOCIATES Fax 603-665-9360**

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

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