Authorization to Release Medical Records

Instructions:

1. Please complete this entire record.
2. Please allow 7-10 days for New Hampshire NeuroSpine Institute to process your request
3. In accordance with our policy, if you are releasing records to yourself, they will be mailed to you in 7-10 business days. Records will not be available for pick up in any of our offices.
4. Pursuant to New Hampshire State Law Chapter 332-I section 332-I: 1 you will be charged $15.00 for the first 30 pages and an additional $0.50 for each additional page.
5. As a courtesy we will forward a copy of your records to a medical provider's office at no charge.

I hereby authorize the disclosure of information from health records of:

Patient name:	Patient DOB:	Office use only: MR#
Street Addresss	City, State and Zip	
Primary Telephone	Alternate #	

Method of disclosure:

☐ Release records from New Hampshire NeuroSpine Institute to:
Name: _____
Address: _____
Telephone & Fax: _____

☐ Release records to New Hampshire NeuroSpine Institute from:
Name: _____
Address: _____
Telephone & Fax: _____

Please send records to the main office: 4 Hawthorne Drive, Bedford, NH 03110
T(603)472-8888 F(603)472-9090

Information to disclose:

Progress notes ☐ Telephone Message/Chart notes ☐ Testing- Films/CD ☐
Hospital/Op notes ☐ Correspondence ☐ Other ☐ _____
Lab/Xray reports ☐ All Records ☐
Please indicate if there is a date range: _____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient or authorized representative Date

_____ _____
Printed name of patient or representative Date

For office use only: ☐ Patient requesting records Initials: _____ Date: _____
☐ Fee obtained Amount: _____ Method: _____