WHOLE HEALTH CONCORD
Individualized Health Care, Naturally!

Medical Records Release Form

Please note: Records that consist of more than 5 pages should be mailed rather than faxed.

Last name _____ First name _____ MI _____ Date of Birth _____

I hereby authorize:

( ) Whole Health Concord
91 N. State Street
Concord, NH 03301
P: (603) 369-4626

( ) _____
_____
_____
P: _____

To release information to:

( ) _____
_____
_____
P: _____

( ) Whole Health Concord
91 N. State Street
Concord, NH 03301
P: 603-369-4626

PURPOSE OF DISCLOSURE:

( ) Continuing care
( ) Payment of claim
( ) Legal
( ) Other (specify): _____

( ) Worker's compensation
( ) School
( ) For personal use

_____

INFORMATION TO BE RELEASED

Between the dates of: _____

( ) Progress notes/Provider notes
( ) Lab reports/Pathology
( ) X-Ray reports
( ) X-Ray films/MRI
( ) Other (specify content and dates):

_____
_____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is one year.
- understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations.
- understand by authorizing this use or disclosure of information there will be no conditions placed on my health care or payment for my health care.
- understand I will receive a copy of this form after I have signed it.

_____ _____ _____
Signature of patient, parent of minor, or personal representative Relationship Date

AUTHORIZATION for USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION