WHOLE HEALTH CONCORD
Individualized Health Care, Naturally!

# MEDICAL RECORDS RELEASE

**Last name** **First name** **MI** **Date of Birth**

**I hereby authorize:**
( ) Whole Health Concord
7 Broadway
Concord, NH 03301
P: (603) 369-4626

( )_____
_____
_____
P: _____

**To release information to:**
( ) _____
_____
_____
P: _____

( ) Whole Health Concord
7 Broadway
Concord, NH 03301
P: 603-369-4626 F: 603.369.4627

**PURPOSE OF DISCLOSURE:**
( ) Naturopathic 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