THOMAS M. ALBUSHIES, M.D.
CHRISTINE M. ARSNOW, M.D.
WENDY BROWN-PERRY, APRN
GABRIELLA A. CHIBBARO, D.O.
DOLLY R. COURTEMANCHE, M.D.
ELIZABETH R. CRAMER, M.D.
PATRICIA M. EDWARDS, M.D.
NATHAN W. FAULKNER, M.D.
JUDITH A. MITCHELL, APRN

248 PLEASANT STREET, SUITE 2600
CONCORD, NEW HAMPSHIRE 03301

(603) 224-1929
FAX (603) 228-7114
www.concordpediatricsnh.com

Authorization to Disclose Protected Health Information

IF YOU ARE TRANSFERRING RECORDS TO ANOTHER FACILITY FROM CONCORD PEDIATRICS, PA

_____ _____

Patient's Full Name Date of Birth

I authorize Concord Pediatrics, PA to share my health information with:

Name of Person/Entity: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

Telephone Number: _____

I would like my records mailed to the above name/address **or** if I prefer to pick up the records, please contact me at this number when the records are available for pick up: _____

For the following purposes:

__Provider Transfer __Other (specify):_____

Type of information requested:

___Abstract (includes any available documents below Other health information

Or check only those documents needed): __Assessments __Nurses' Notes

__Progress Notes __Emergency Dept Notes __Itemized Bill

__History & Physical __Consultation __Other_____

Dates of care to be released:_____to_____

I UNDERSTAND THAT:-Upon request, I can inspect or obtain a copy of the information I am authorizing to be released. A fee for the costs of processing this request may be charged.

_Once I authorize the disclosure of my health information, it is no longer protected information and re-disclosure by the recipient is legally permitted.

The following types of information WILL BE INCLUDED UNLESS INDICATED BY YOU INITIALING BELOW:

Drug and/or alcohol treatment Initials:___ Psychiatric Initials:___

Sexually transmitted disease Initials:___ Genetic Treatment Initials:___

HIV (AIDS) testing/treatment Initials:___

This authorization expires six months from the date of signature or on:_____

_____ _____ _____

Signature of patient or legal representative/guardian Authority or relationship of representative Date