Authorization to Disclose Health Information

I authorize Laconia Women's Health Center, PLLC to disclose the protected health information to (for your new provider- records will only be sent with full address included)

Name:____

Address:____

____

This authorization for release is for records from _____________ to ________________
(Dates- such as past 3 years, all records, or specified time frame)

□ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
OR
□ I authorize the release of my complete health record with the exception of the following information:

- □ Mental health records
- □ Communicable diseases (including HIV and AIDS)
- □ Alcohol/drug abuse treatment
- □ Other (please specify):

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

____DOB:________
Signature of patient or personal representative

____
Printed name of patient or personal representative and his or her relationship to patient

If we have any questions, how may we reach you? Phone ____________________

Email____________________________________

Today's Date: _______________________________

Laconia Women's Health Center 501 Union Ave #3 Laconia, NH 03246