Authorization to Disclose Health Information

I authorize Laconia Women's Health Center, PLLC to disclose the protected health information to (put in your name if being sent directly to you):
Name:_____

Address:_____

_____

This authorization for release is for records from _____ to _____
(Dates- such as past 3 years, all records, or immunization records, for example)

Check one of the following boxes:
□ 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.

_____
Signature of patient or personal representative Date of Birth of Patient

_____
Printed name of patient or patient and personal representative if authorizing agent is signing and his or her relationship to patient. Minors need to have a parent sign.

If we have any questions, how may we reach you? Your Phone _____ and

Your Email_____ Today's Date: _____
Fax to (844)912-1690) or mail to Nancy Dirubbo 184 Hickory Stick Lane Laconia NH 03246