454 Old Street Road
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Peterborough, NH 03458
603-924-9444

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Release of/Request for Healthcare Information

Patient Information:

Name:_____Date of Birth:_____

Address:_____City:_____State:_____Zip:_____

Phone:_____

Release to / From: Monadnock OBGYN Associates PA
454 Old Street Road Suite 302
Peterborough, NH 03458
(603)924-9444 Fax: (603)924-8709

Release to / From:

Practice Name:_____

Address:_____City:_____State:_____Zip:_____

Phone:_____Fax:_____

Information to be released: (Check all that apply)

GYN Record	□	Labs/Pathology/PAPS	□	X-ray/Ultrasound	□
Pregnancy Record	□	Operation Report	□	Other	□

Including Sensitive Information: (*Required to be checked off individually in order to be released)

Mental Health	□	HIV Diagnosis/Treatment	□
Alcohol/Drug Use/Treatment	□		

Dates of service to be released:

ALL	□	Most Recent	□	Past 5 Years	□

How to be released:

Picked up	□	Mailed	□	Faxed (Read release below)	□

I am aware that the above requested information is to be release via fax machine. I am also aware of the risks associated with faxing or mailing protected/sensitive health information including, but not limited to: erroneous transmission, lack of confidentiality safeguarding at the site of receipt and incomplete transmission of information.

Purpose of request:

New PCP:	□	Continued Care:	□	Personal:	□
Legal:	□	Insurance:	□	Auto:	□
Work:	□	Other:	□		

Understandings:

I understand that the information released is confidential and must be used for the purpose that it was requested for; however, once this information is disclosed, the information is subject to re-disclosure and may no longer be protected by federal privacy regulations. I may revoke this authorization at any time in writing or verbally, if followed by written confirmation. There may be an administrative fee of $15.00 for the first 1-30 pages and .50 cents per page thereafter. I have read or have had this entire form read to me. I understand the content. I hereby authorize the release of my Private Health Information stated above and excuse the releasing party from any legal responsibility or liability relating to the release of information. This authorization is considered valid for a period of ninety days from the date of signature. The date of authorization may not precede the date(s) of service(s) being requested.

Patient /Parent/Legal Agent Signature: (Relationship if necessary) Date