



AUTHORIZATION TO RELEASE OR REQUEST MEDICAL INFORMATION

Medical Records Department
603-862-1987/Fax 603-862-4259

12 Ballard St.
Durham, NH 03824-3577

Patient's name: _____ Date of birth: _____

Address: _____

Patient's SSN#: _____ Phone: _____

Permission is hereby given for UNH Health Services to release/request the following information from the medical record: **Check one:** **RELEASE TO** **REQUEST FROM**

Name: _____ Phone _____

Street: _____ Fax _____

City: _____ State _____ Zip _____

Permission for coordination of services from UNH Counseling Center
Information and dates to be disclosed: From (date) _____ To (date) _____

Physician/nursing notes X-ray reports History & physical exam

Laboratory tests Complete health record _____
(other)

PURPOSE FOR RELEASE OF INFORMATION: _____
(Physician, Lawyer, Insurance, Other)

SPECIFIC CONSENT IS REQUIRED TO RELEASE THIS INFORMATION

(Please sign below if you wish to disclose the following information)

Sexual assault: _____ HIV/AIDS: _____

Mental Health: _____ HIV testing results: _____

Drug/Alcohol: _____ Sexually Transmitted Disease: _____

Other: _____ Pregnancy: _____

THIS AUTHORIZATION IS VALID FOR 90 DAYS

I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken in response to this authorization. I also release UNH Health Services from any liability or legal responsibility in connection with the release of the above information. I understand that the potential for information disclosed pursuant to this authorization is subject to re-disclosure by the recipient (other than UNH Health Services), which would be beyond the control of UNH Health Services, and may no longer be protected by federal law.

RISKS AND CONSEQUENCES OF FAXING MEDICAL RECORDS ACCEPTED o

TYPE OF REQUEST:

- Mail directly to UNH Health Services, Attention Medical Records
- For pickup Mail to patient Mail to addressee Verbal Other

Patient Signature Date Witness Signature

UNH Health Services does not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization or not.