

Authorization for Release of Health Information University of New Hampshire Health & Wellness

4 Pettee Brook Lane Durham, NH 03824 Phone: (603) 862-9355 Fax: (603) 862-4259

Step 1	Information about you:
Please fill in your demographic information	Patient Name:Date of Birth:
Illioiniation	Address:
	Phone Number: Student ID:
Step 2 Provide us with as much information as possible	I hereby authorize: University of New Hampshire Health & Wellness 4 Pettee Brook Lane Durham, NH 03824 Phone: (603) 862-9355 Fax: (603) 862-4259
Step 3 Provide us with as much information as possible	To release my records to/obtain my records from:
	Type of Disclosure (circle one): Verbal Fax Paper Copy
	We are unable to send medical records via email as our system is not a secure method for the transmission of PHI.
Step 4 Please read carefully and authorize the	If my initials appear here:, I authorize the release of ALL RECORDS which include office notes, lab reports, diagnostic imaging, problem list, medication list and Immunization records.
information to be	OR
released	Release only the following:
	Specific Dates:
Step 5 Please read thoroughly, sign and date	I understand that if my medical record contains information regarding <i>drug and/or alcohol abuse</i> , <i>psychiatric treatment</i> , <i>HIV/AIDS testing and/or treatment</i> , I agree to the release of those sensitive records by signing below.
	Patient Signature/Legal Guardian Date
Step 6 Please read thoroughly, sign and date	I have carefully read and understand the above statement, and so herein expressly and voluntarily consent to the disclosure of the above information about, or medical records of my condition to those persons or agencies named above. I hereby release the above-named physician, covering physicians, and facility from any liability that may arise from the release of my medical records. By signing I also am consenting to the understanding that requests for copies of health records are subject to reproduction fees in accordance with state & federal regulations. This authorization will expire 12 months from the date signed below.
	Patient Signature/Legal Guardian Date

Completed forms can be faxed, mailed, or emailed to health@unh.edu