

**Nashua Medical Group**  
**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Cell Phone :** \_\_\_\_\_

I authorize **Nashua Medical Group** release of my Protected Health Information to the following listed below:

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
# street city state zip

**Purpose of the release:** Permanent Transfer \_\_\_\_\_; Personal Copy \_\_\_\_\_; Other \_\_\_\_\_

**Reason for leaving:** Insurance Change \_\_\_\_; Out of town move \_\_\_\_; Dissatisfied with service \_\_\_\_; Other \_\_\_\_\_

**Dates of Service:** \_\_\_\_\_ to \_\_\_\_\_

\_\_\_ Complete Copy of Medical Record    \_\_\_ Office Notes    \_\_\_ Lab Reports  
\_\_\_ Immunization Records            \_\_\_ Growth Chart    \_\_\_ X-Ray/Diagnostic Imaging Reports  
\_\_\_ Other (describe): \_\_\_\_\_

**Please initial the following if applicable:**

- \_\_\_ I specifically authorize the release of HIV/AIDS results  
\_\_\_ I specifically authorize the release of information in reference to drug and or alcohol abuse protected by Federal Regulation 42CFR  
\_\_\_ I specifically authorize release of psychiatric/neuropsychiatric record  
\_\_\_ I specifically authorize release of sexual assault/physical/verbal abuse record.

I understand that consent is subject to revocations at any time in writing except if the medical records have already been disclosed or if the authorization was signed as a condition of obtaining my insurance coverage as explained in St Joseph Healthcare's Notice of Privacy Practices.

I understand that if health information is disclosed by this authorization, it may no longer be protected under the terms of the privacy rules and the recipient may be able to legally re-disclose the health information to others.

I have carefully read and understand the above statements. I hereby release SJ Physician Services from all legal responsibility or liability from the release of these medial records.

This authorization expires 90 days from the date signed below or otherwise stated below:

\_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Patient/Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient

*Pursuant to NH Senate Bill 42, the fee for copies is \$15.00 for the first 30 pages and \$.50 for every page after*