Name_____ DOB_____

New Hampshire State Law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions.

( ) Records of cares/treatment for HIV/AIDS Initials_____

( ) Records of Mental Health Care and treatment Initials_____

( ) Records of Substance Abuse Initials_____

Purpose of release of medical record information:

( ) Transferring Care

( ) Specialist Referral

( ) Required for School or Camp

( ) Other _____

( ) FAX RELEASE: I AM AWARE THAT THE ABOVE REQUESTED INFORMATION IS TO BE RELEASED VIA A FAX MACHINE. I AM ALSO AWARE OF THE RISKS ASSOCIATED WITH THIS FORM OF ELECTRONIC TRANSMISSION INCLUDING BUT NOT LIMITED TO ERRONEOUS TRANSMISSION, LACK OF CONFIDENTIALITY SAFEGUARDS AT THE SITE OF THE RECEIVING MACHINE, AND INCOMPLETE TRANSMISSION INFORMATION.

Reason for Transfer _____

_____

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

Expiration Date: This authorization will expire on _____. If no date is stated, this authorization expires six months from the date it was signed.

Charges: There is a $20.00 fee for record preparation and mailing for each complete medical record transferred. Fee shall be paid prior to starting the transfer process. There is no charge for records going to MD we have referred your child to.

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENITALITY IS PROTECTED BY FEDERAL LAW. FEDEREAL REGULATIONS PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT SPECIFIC WRITTEN CONSENT OF THE PERSON OR LEGAL REPRESENTATIVE TO whom it pertain.