Londonderry Pediatrics
25 Buttrick Road, Bldg. E
Londonderry, NH 03053

Patient Legal Name	Birth date	Social Security No.

Address ______________________ Telephone No. ______________

City ______________________ State __________ Zip Code ______________

For Disclosure Only

I hereby authorize ______________________
Practice Name or Physician

Address

Telephone number: Fax number:

To disclose medical record information and/or protected health information of the patient listed above to:

Londonderry Pediatrics
Name / Title

25 Buttrick Road, Bldg. E, Londonderry, NH 03053
Address

Purpose: ______________________

For treatment date(s) (if applicable): ______________________

Type of Access Requested:

☐ Copies of the record

☐ Inspection of the record

Selected Portions of PHI:

☐ Entire Record
☐ Emergency Room
☐ History & Physical
☐ Consult Report
☐ Operative Report
☐ Rehabilitation Services

☐ Lab
☐ Imaging/Radiology
☐ Cardiac Studies
☐ Demographics
☐ Nursing Notes
☐ Medication Record

☐ Progress Notes
☐ Physician Orders
☐ Billing Records
☐ *Internal* Marketing
☐ Other ______________
____

Expiration: This authorization shall expire upon (check one):

☐ Fulfillment of this request (according to HIPAA or State Regulations, whichever is shorter)

☐ Date ______________

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.

I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

Fees/charges will comply with all laws and regulations applicable to release of information.

I have read the above and authorize the disclosure of the protected health information as stated.

Date **Signature of Patient/Parent/Patient Representative** **Relationship to Patient**

Address and telephone number of Requestor (if different from patient information)

POS® Reorder # 1114623