

# Whole Life Health Care-- Release of Healthcare Information

100 Shattuck Way Suite 100 Newington, NH. 03801 Phone: 603-431-6677 Fax: 603-610-2232

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Office to Release:

\_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_

Office to Receive:

\_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_

Please initial next to information to be released:

- \_\_\_\_\_ Medical History/ Treatment Records/ Progress Notes
- \_\_\_\_\_ Last Annual Exam and Pap Test
- \_\_\_\_\_ Laboratory/ Diagnostic Tests \_\_\_\_\_ All
- \_\_\_\_\_ Sexually Transmitted Diseases
- \_\_\_\_\_ HIV/ AIDS
- \_\_\_\_\_ Drug or Alcohol Abuse/ Treatment
- \_\_\_\_\_ Mental Health Illness/ Treatment
- \_\_\_\_\_ Immunization Records
- \_\_\_\_\_ Other \_\_\_\_\_

Circle One:

Transferring Care

Sharing Care

If transferring, please give reason: \_\_\_\_\_

I understand that:

- ~I can see and copy the health information described above.
- ~I can refuse to sign this authorization and that my refusal will not affect payment, eligibility for benefits or my ability to obtain treatment.
- ~I can revoke this authorization in writing to the address above at any time, but my revocation will not apply to information that has already been disclosed or used in response to this authorization,

Patient / Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Consent expires one year from date signed

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