Lafayette Family Care

264 Lafayette Road, Suite 8
Portsmouth, NH 03801
Phone: (603) 433-3636 Fax: (603) 433-3939

Authorization for Release of Medical Records

Patient Name: _____ Birth Date: _____ SSN: _____
Requestor Name (If requestor is not the patient): _____
Requestor Phone Number: _____ Relation to Patient: _____

I give permission to Lafayette Family Care to:

☐ Obtain my medical records from: ☐ Give my medical records to:
Name of Practitioner/Hospital/etc:_____
Address: _____
City: _____State:_____ Zip Code: _____
Telephone Number: _____ Fax Number: _____

The reason for this disclosure of information: ____ Transfer of care (new PCP)
____ Seeing specialist
Other (please specify): _____

You may disclose the following health information:

☐ Medical records on file from other health care practitioners:_____

☐ Information about my health care while I was a patient at Lafayette Family Care

☐ Only the following records may be disclosed : _____
_____

I understand that:
1. I can cancel this authorization in writing at any time and that it is strictly voluntary.
2. I can refuse to disclose some or all of my records, but such refusal could result in an improper diagnosis, treatment, denial of health benefits, denial of insurance claim, or other adverse consequences.
3 A record is not within the control of Lafayette Family Care once the record is disclosed to the designee.
4. I am entitled to a copy of this authorization from.

I authorize the disclosure of my protected health information. I acknowledge that I have been provided the opportunity to review Lafayette Family Care's Notice of Privacy Practices. A copy of this authorization shall be valid as the original. I consent to disclosure of the information for through future 12 months, or for a shorter period of time if so requested: _____

X_____/_____/_____
Signature of Patient/Authorized Representative Date of Birth Date