



# Whole Health Concord

Naturopathic Medical Center

Dr. Laura Riley

## Medical Records Release Form

**Please note: Records that consist of more than 5 pages should be mailed rather than faxed.**

\_\_\_\_\_  
Last name                      First name                      MI                      Date of Birth

**I hereby authorize:**

( ) Whole Health Concord  
114 S. State St.  
Concord, NH 03301  
P: (603) 369-4626

( ) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
P: \_\_\_\_\_

**To release information to:**

( ) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
P: \_\_\_\_\_

( ) Whole Health Concord  
114 S. State St.  
Concord, NH 03301  
P: 603-369-4626

**PURPOSE OF DISCLOSURE:**

- |   |  |
|---|--|
| <input type="checkbox"/> Continuing care  | <input type="checkbox"/> Worker's compensation |
| <input type="checkbox"/> Payment of claim | <input type="checkbox"/> School                |
| <input type="checkbox"/> Legal            | <input type="checkbox"/> For personal use      |
- Other (specify): \_\_\_\_\_

**INFORMATION TO BE RELEASED**

Between the dates of: \_\_\_\_\_

- |  |       |
|--|-------|
| <input type="checkbox"/> Progress notes/Provider notes | _____ |
| <input type="checkbox"/> Lab reports/Pathology         | _____ |
| <input type="checkbox"/> X-Ray reports                 | _____ |
| <input type="checkbox"/> X-Ray films/MRI               | _____ |
- Other (specify content and dates): \_\_\_\_\_

**ACKNOWLEDGEMENT OF UNDERSTANDING:**

- I understand the expiration date of this authorization is one year.
- understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations.
- understand by authorizing this use or disclosure of information there will be no conditions placed on my health care or payment for my health care.
- understand I will receive a copy of this form after I have signed it.
- I understand that in compliance with MN Statue 144.33 and WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.

\_\_\_\_\_  
Signature of patient, parent of minor, or personal representative                      Relationship                      Date

**AUTHORIZATION for USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**