



Whole Health Concord

Naturopathic Medical Center
Dr. Laura Riley Jones

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 314 S. Main
Street Concord, NH
03301
P: (603) 369-4626

P: _____

To release information to:

P: _____

Whole Health Concord
314 S. Main Street
Concord, NH 03301
P: 603-369-4626

PURPOSE OF DISCLOSURE:

- Continuing care
- Payment of claim
- Legal
- Other (specify): _____

- Worker's compensation
- School
- For personal use

INFORMATION TO BE RELEASED

Between the dates of: _____

- Progress notes _____
- Lab reports/Pathology _____
- X-Ray reports _____
- 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.

Signature Relationship Date

AUTHORIZATION for USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION