One Parkland Drive
Derry, NH
03038

P 603 432-1500
www.parklandmedicalcenter.com

Patient's Name | Date of Birth | Social Security #/ID | Unit No.

Address | Town, State, Zip | Phone No.

I authorize my records to be released to: ______________________________
Name of Person/Facility

____
Full Address

Dates of Treatment to be released: ______________________________

To be released from:

Parkland Medical Center
One Parkland Drive
Derry NH 03038

For the purpose of: ______________________________

Including the following portions of the record (s):

( ) Abstract/Pertinent Information
( ) Entire ER
( ) Face Sheet
( ) History & Physical
( ) Discharge Summary
( ) Consultations
( ) Operative Report
( ) Progress Notes
( ) Nursing Notes
( ) Physician Orders
( ) Lab
( ) Imaging/Radiology _______
( ) Cardiac Studies
( ) Entire Record
( ) Other ______

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I acknowledge, and hereby consent to such, that the released information may contain **PSYCHIATRIC** records, **HIV** testing, **HIV** results, or **AIDS** information. I also understand that any disclosure is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of **ALCOHOL** and **DRUG ABUSE** patient records and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. This facility is released and discharged of any liability, and undersigned will hold the facility harmless, for complying with this **Authorization for Release of Medical Information.**

This authorization expires 60 days from the below date, and covers only treatment periods above.

Signed: ______________________________ **Witness:** ______________________________

Identification: ______________________________ **Date:** ______________________________

NOTICE to the person or agency receiving information: Federal laws and regulations prohibit redisclosure of the information whose confidentiality is protected in the absence of specific consent of the patient or person authorized to consent for the patient.

Fee/Charges will comply with all laws and regulations applicable to release of information.

Authorization for Release of Medical Information