ALL CARE MEDICAL
22 MAIN STREET
SALEM, NEW HAMPSHIRE 03079
TEL: (603) 893-7905 FAX: (603) 898-6106

RECORD RELEASE AUTHORIZATION

Name:____ DOB:________________

Address:____ Phone:________________

ALL CARE MEDICAL Is Authorized to Release/Obtain Medical Information To/From:

Provider:____

Address:____

Phone & Fax:____

☐ **I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS** including records or copies of medical records relating to diagnosis, treatment of services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, HIV, alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion and illegitimacy of birth.

☐ I GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below:

____

____

By signing below, I understand that this information is not to be released to any person or facility without my written consent except as otherwise specifically provided by law. I understand that this consent is subject to revocation at anytime. However, any release which was made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breech of my right to confidentiality.

______________________________ ___________ _________________________________

Signature (Parent/Guardian for Minor) **Date** Signature of Witness

So that we may improve our patient care, please let us know the reason you are requesting this record release:

☐ Not satisfied with Provider (which Provider?)______________________
☐ Not satisfied with Staff (which Staff Member?)_____________________
☐ Moving out of the area.
☐ Other (please describe)____