performancehealth
SPINE & SPORT THERAPY

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Instructions:

1. Please complete this entire form.
2. Please allow 7-10 days for Performance Health to process your request.
3. Pursuant to New Hampshire State Law RSA 332-I: you will be charged a flat rate of $15 for up to 30 pages. Additional pages will be processed at a rate of $0.50 per page.
4. As a courtesy, we will forward a copy of your records to a medical provider's office at no charge.

I hereby authorize the disclosure of information from health records of:

Patient Name:	Patient DOB:
Address:	City, State, Zip:
Primary Phone:	Alternate Phone:

Method of Disclosure:

☐ Release records **from** Performance Health to:

Name:
Address:
Phone & Fax:

☐ Release records **to** Performance Health from:

Name:
Address:
Phone & Fax:

Please mail/fax records to: 91A North State Street | Concord, NH 03301
P: 603.724.2297 F: 603.369.3017

Information to disclose:

Treatment Notes ☐ Lab/MRI/X-Ray Reports ☐ X-Ray/MRI Disc ☐ All Records ☐

Please indicate if there is a date range: _____

**Note: If these records contain any information from previous providers about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are authorizing disclosure of this information.*

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of patient or authorized representative Date

_____

Printed name of patient or representative