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CONCORD, NEW HAMPSHIRE 03301
Phone (603) 224-1929
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Record Release Form

Please Print Clearly

Patient Name _____ **DOB** _____

Mailing Address _____ , _____, _____ _____
Street City State Zip code

I authorize Concord Pediatrics PA to ☐Disclose ☐ Receive (choose one) medical records from/to the following source:

Facility _____ **Provider** _____

Mailing Address _____ , _____, _____ _____
Street City State Zip code

Phone number _____ **Fax number** _____

For the following purpose: ☐ Transfer of Care ☐ Continuation of Care ☐ Other _____

I give permission to release:

☐ **All Medical Records**

☐ **Abstract including :** ☐ Progress Notes ☐ History and Physical Examinations ☐ Last Physical Examination

☐ Other _____

☐ **Medical Records with dates of service from** _____ **to** _____

☐ **Only the following Medical records:** _____

Sensitive information including Substance Abuse, STDs, Psychiatric treatment and Genetic treatment will be included unless indicated by initialing below:

___ Drug and/or Alcohol treatment **___ Psychiatric treatment**

___ Sexually transmitted diseases **___ Genetic treatment**

___ HIV (AIDS) testing/treatment

I understand that the information disclosed per this authorization may be subject to redisclosure and no longer protected. I have the right to revoke this authorization at any time by submitting a written statement to CPPA and that to the extent that information has already been disclosed/received in reliance on this authorization.

Signature of Patient or Guardian _____ **Date** _____

Print Name _____ **Relationship to Patient** _____