NEW HAMPSHIRE REGENERATIVE CENTER
765 S. MAIN STREET SUITE 103
MANCHESTER NH 03102

PHONE (603) 945 1945
FAX (603) 441 3255

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT _____ **DOB** _____

DATE OF RECORDS _____

I, the undersigned, request access to the information specified below from the medical record(s) of the above-named patient.

PATIENT INFORMATION IS NEEDED FOR: CONTINUING MEDICAL CARE

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical Office Notes **X-Ray/MRI** (Reports AND Images)

The above information may be released;

TO: NEW HAMPSHIRE REGENERATIVE CENTER, LLC
FAX: (603) 441 3255

FROM: _____
(Imaging Facility, Doctor, Hospital, Attorney, Self, etc.)
CITY/STATE OF FACILITY: _____

I Understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that by signing this form, I authorize the release of my medical records as described above. I understand that this authorization is voluntary and may be revoked in writing at any time, except to the extent action has already been taken. I certify that I am the patient or the patient's authorized representative and have the authority to sign this form.

SIGNATURE: _____ **DATE**: _____

_____

Printed Name of Patient *or Legally Authorized Representative*