New Hampshire Regenerative Center
765 South Main Street, Suite 103
Manchester, NH 03102
Tel 603.945.1945
Fax 603.441.3255

Authorization to Release Medical Records

Name of Patient _____ Date of Birth _____

Date(s) of Records _____

I, the undersigned, authorize the release of, or 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 Consultation Report Emergency Room Record X-Ray/MRI Reports & Images

The above information may be released;

TO: NEW HAMPSHIRE REGENERATIVE CENTER, LLC

FAX # (603) 441 3255

_____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number / Fax Number

FROM:

FAX #:

_____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number / Fax Number

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legally Authorized Representative **Relationship to Patient**