CONSENT TO OBTAIN MEDICAL RECORDS FROM

_____
_____
_____
_____

1. I, _____DOB:_____authorize the release of my:
X-Rays: _____ Please note, X-Rays must be returned by: _____

Medical Records:

_____ Initial here and specify the injury or condition you would like the records sent on.
If you do not initial here, records on all injuries or conditions will be sent.

Injury/Condition: _____

_____ Initial here for the release of **Office Notes**
_____ Initial here for the release of **Radiology Reports**
_____ Initial here for the release of **Operative Notes**
_____ Initial here for the release of other records, as specified herein:
_____
_____
_____

Medical Records and/or X-Rays to be sent to:

NHOC – 17 RIVERSIDE STREET, SUITE 101, NASHUA NH 03062 – FAX # 603-864-1711

_____ I give my permission for my records to be sent via mail or fax. If you do not initial here your records will not be sent.

2. If my initials appear here, I specifically authorize the release of the following:
_____ HIV status _____ Communicable disease history
_____ Alcohol and drug history _____ Mental Illness

I understand that this information cannot be disclosed without my written consent except as otherwise specifically provided by law. I understand that by law, I need not to consent to the release of this information. However, I choose to do so willingly and voluntarily for the purpose specified above.

3. I have carefully read and understand the above statements. I hereby release this practice from all legal responsibility or liability whatsoever that may arise from the release of medical records or X-rays (originals or copies).

_____	_____	_____
Date	Signature (Patient or Responsible Adult)	Relationship if other than Patient

_____	_____
Date	Witness