Niña Iselin N.D.

174 Concord St. Peterborough N.H. 03458 **102 Pleasant St. Concord N.H. 03301**
Ph: (603)827 3971
FAX: (603) 924 6679 **FAX: (603) 856 8041**

AUTHORIZATION TO RELEASE HEALTH INFORMATION

_____ _____ _____
Patient's Full Name Date of Birth patients phone number

I hereby authorize:
I authorize ( ) _____

_____

PH: _____FAX:_____

To release information to:
( ) Niña Iselin N.D.
102 Pleasant St Concord NH 03301 FAX: 856 8041
172 Concord St Peterborough NH 03458 FAX:924 6679
PH: 603 827 3971

I hereby authorize:
( ) Niña Iselin N.D.
102 Pleasant St Concord NH 03301 FAX: 856 8041
172 Concord St Peterborough NH 03458 FAX:924 6679
PH: 603 827 3971

To release information to:
( )_____

_____

PH:_____FAX_____

For the purpose of: ( ) continuing care/consult ( ) transfer to new provider
( ) payment of claim ( ) Consultation with: _____
( ) legal Other _____

This release includes specifically:
( ) Office Notes ( ) Laboratory Reports
( ) Complete Record ( ) Radiology Reports
( ) EKG ( ) Other: _____

Covering records from:
1) The period from _____ to
_____
2) Date of service _____ to_____

I understand that the information I have agreed to release to the aforementioned party may include sensitive clinical information obtained during the dates listed above. These may or may not include treatment of substance or other abuse, HIV, psychiatric disorders, sexually transmitted diseases, etc., unless herein excepted: _____

I UNDERSTAND THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON THIS AUTHORIZATION. UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE IN SIX MONTHS FROM THE DATE SIGNED, OR UNTIL THE FOLLOWING EVENT OR CONDITION:_____

SIGNATURE (person authorizing release): _____

Date of Signature: _____ Relationship to Patient: _____

WITNESS _____DATE_____

A FEE MAY BE ASSESSED TO PROCESS YOUR REQUEST. PLEASE ALLOW FIVE BUSINESS DAYS TO RELEASE YOUR RECORDS