

Authorization to Disclose Health Information

I authorize Travel Health of New Hampshire, PLLC to disclose the protected health information to :

Name: _____

Address: _____

This authorization for release is for records from _____ to _____
(Dates- such as past 3 years, all records, or immunization records, for example)

Check one of the following boxes:

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

I authorize the release of my complete health record with the exception of the following information:

Mental health records

Communicable diseases (including HIV and AIDS)

Alcohol/drug abuse treatment

Other (please specify):

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Signature of patient or personal representative

Date of Birth of Patient

Printed name of patient or personal representative and his or her relationship to patient if not the patient. Minors need to have parent sign.

If we have any questions, how may we reach you? Phone _____

Email _____ Today's Date: _____

Fax to (844)912-1690) or mail to Travel Health c/o Nancy Dirubbo 184 Hickory Stick Lane
Laconia NH 03246