PROGRESSIVE SPINE & REHAB CENTER

1850 Elm St. Manchester, NH 03104
P: 603-641-4800 ■ F: 603-6223199

AUTHORIZATION TO RELEASE OR REQUEST PROTECTED HEALTH INFO

PATIENT INFORMATION

Patient Name:____ Date of Birth:__________
Address:____
City:______________________________ State:__________________ zip:___________
Phone Number: (____)______________

AUTHORIZATION TO: (Check One)

☐ *Release* Patient Information to: **Progressive Spine and Rehab Center**
Street: **1850 Elm Street** City/State: **Manchester, NH 03104**

☐ *Request* Patient Information from: ____
Street: ______________________________ City/State:________________________

HEALTH INFORMATION TO BE RELEASED OR RECEIVED

Copies of my health information within the following dates: _____________ to _____________.

☐**Abstract *OR check only those documents needed:***

☐ Discharge Summary ☐ Emergency Department Reports ☐ Immunizations
☐ Inpatient Progress Notes ☐ Laboratory/Pathology Reports ☐ Operative Reports
☐ Outpatient Visit Notes ☐ Medical Image Report (report only) __________________
☐Other: (Please Specify) ____

Delivery Preference: ☐ Pickup ☐ Mail ☐ Fax (for Medical Care purposes) – Fax#:

PURPOSE for which this patient information is being requested/ released: (Check One)

☐ Medical Care ☐ Insurance ☐ Legal ☐ Personal ☐ School
☐ Transferring Out of Practice ☐ Other: (Please Specify) ___________________

ADDITIONAL INFORMATION

I understand that:

- I may obtain a copy of the protected health information described by this Authorization.
- Progressive Spine and Rehab Center shall not condition treatment on my providing authorization for the requested use or disclosure; I may refuse to sign this authorization.
- Information used or disclosed pursuant to this Authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- I understand that it is my sole responsibility to safeguard any of my protected health information provided to me directly, and that Progressive Spine and Rehab Center shall not be liable for any subsequent acquisition, access, use or disclosure.

EXPIRATION DATE: This Authorization is valid until: ______________

(If no date/event is stated, this Authorization expires one year from the date it was signed.)

SIGNATURE

____ ________________________
Signature of Patient or Personal Representative Date

____ ________________________
Printed Name Relationship to Patient