Family Health Matters Of Salem
32 Stiles Road
Salem NH 03079-2859
603-386-0100 603-386-0076

Authorization for Release of Medical Records

Patient Name:_____Date of Birth: _____
Address:_____
_____
Phone:_____
I hereby authorize **FAMILY HEALTH MATTERS OF SALEM** *to take the following action:*

· **Release** My Health Information to:
My email address:_____
OR
USB to be picked up at Family Health Matters:_____

If you require your records to be mailed please contact us directly as this requires an additional fee and we require FedEx or UPS overnight with insurance confirmation. This may also delay the release of your records due to processing times

Patient information to be released:

· Last Physical Exam	· PAP	· Colonoscopy
· Last office note	· Bone Density	· MMG
· Immunizations	· Eye Exam	· Entire Medical Record

Purpose for which this information is being released:
· Seeing a specialist
· Permanent Transfer to another Provider
***There is a $15.00 charge to transfer your medical records**

OR

· **Obtain** copies of My Health Information from:
Facility Name: _____
Phone:_____ Fax:_____
Patient information to be released:

· Last Physical Exam/ Last office note		· PAP	· Colonoscopy
· Bone Density	· MMG	· Immunizations	· Eye Exam
· Entire Medical Record	· MISC_____		

- **I Understand:** The information released is confidential and must be used for the purpose that it was requested for; however, once this information is disclosed, the information may be subject to re-disclosure and may no longer be protected by federal and state confidentiality laws. I may revoke this authorization at any time in writing, provided the information has not already been disclosed in reliance on this authorization. I know that this authorization is voluntary, and I may refuse to sign this form. I understand that refusing to sign this form will not affect my ability to obtain treatment, the payment for my treatment, or my enrollment or eligibility for benefits unless allowed by law.

Patient Name: (print) _____

Patient Signature:_____ Date:_____

****(if patient is under18) parent/guardian signature and relationship to patient**

CK04/03/2023