MANCHESTER-BEDFORD MYOSKELETAL
A New Hampshire Limited Liability Company

Tel. (603) 622-1112
Fax. (888) 965-6870

AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ DOB: _____
(First, MI, Last) *(mm/dd/yyyy)*

Address: _____ Tel. _____
(xxx-xxx-xxxx)

City, State, Zip: _____ Choose _____

I authorize Manchester-Bedford Myoskeletal LLC to ☐ **Release** my Protected Health Information to/from the following:
And/or ☐ **Obtain**

Date Range of Records Requested From (mo/yr): _____ To (mo/yr): _____

Organization: _____

Contact Name: _____ Department: _____

Address: _____

Tel.: _____ Fax: _____

Records Requested: ***(Office Use Only)***

☐ X-rays ☐ MRIs ☐ Radiology Reports ☐ CD/DVD if available

☐ Prescription ☐ Diagnosis ☐ Physicians Clearance for Myoskeletal Treatment (See info attached)

☐ Chart Notes ☐ Assessment ☐ Re-Evaluation ☐ All Records

☐ Other (specify): _____

Purpose of Release: ***(Office Use Only)***

☐ Continuation of care/Physician Referral ☐ Worker's Comp ☐ Auto Insurance ☐ Attorney / Legal case

☐ Attending Physician's records ☐ Other: _____

I authorize the release of my medical records and/or other protected health information as described above. This authorization expires 90 days from date signed below unless otherwise indicated:

_____ _____ Choose _____
Patient/Representative Signature Date Relationship to Patient

_____ _____ _____
Clinic Manager Date Alternate Expiry

Pursuant to NH Title XXX, Ch 332-I (2015), the fee for copies is $15.00 for the first 30 pages and $.50 for every page thereafter