Concord Otolaryngology

Alliance Audiology LLC
Audiology & Hearing Center

194 Pleasant Street Concord, NH 03301-2952 Tel. 603.224.2353 Fax 603.226.0727

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I understand that information disclosed under this authorization might be re-disclosed by the recipient, and that any such re-disclosure may no longer be protected by federal and/ or state law. I release Concord Otolaryngology, and any of its employees, agents, partners, or affiliates from any and all liability arising from disclosure pursuant to this authorization and any re-disclosure of that information.

This authorization is valid for a period of one year unless revoked in writing. I understand revocation cannot be retroactive and will not apply to records previously released. I understand that I am entitled to a copy of this authorization.

I have read and understand this section_____(sign or initial) Date:_____

I, _____, give **Concord Otolaryngology** &/or **Alliance Audiology**, or
(Patient Name/Legal Guardian) (Holder of Patient Records)

their authorized employees and agents permission to release healthcare information regarding their patient

_____ Date of Birth_____) to
(Patient's Name) (Date of Birth)

_____ _____
(Receiving Party) Phone *

_____ _____
(Address) Fax

_____
(City) (State) (Zip Code)

* Phone number of the receiving party is required for any request to fax records.

The purpose of this release is for:_____

Please Release the Following Records: (check off selection and Initial each line)

☐ The entire health care record including history, dates, courses and outcomes of medical treatment, questionnaires, notes, and phone calls. _____ (Please initial) OR

☐ Specific Records (list): _____

I understand that I have the right to refuse to authorize the release of all or some healthcare information but that refusal may result in an improper diagnosis or treatment, denial of coverage or a claim for health benefits or other adverse consequences

☐ I DO ☐ I DO NOT want any information referring to diagnosis or treatment of ALCOHOL/SUBSTANCE ABUSE to be released. _____ (Please initial)

☐ I DO ☐ I DO NOT want any information referring to MENTAL HEALTH to be released. _____(Please initial)

☐ I DO ☐ I DO NOT want to review such information *before* it is released. I understand that any review must be supervised. _____(initial)

☐I DO ☐ I DO NOT authorize disclosure of HIV, AIDS, ARC status, diagnosis or treatment.

Patient Request

Signed _____ Date of Birth _____ Date _____
(Patient / Parent / Legal Guardian -- Please Circle One)

(Consent expires 1 year from this date)

Witness: _____