My Friend's Gynecologist, LLC ~ Dr. Terri Vanderlinde

835 Central Ave. Suite 117 Dover, NH 03820 Ph: 603-516-0000 Fax: 603-516-5001

Protected Health Information Authorization to RELEASE Records

Patient Name: ______________________________ DOB: ____________________
Other Last Names: ______________________________ SSN: ____________________
Address: ______________________________ Phone: ____________________

This will authorize *My Friend's Gynecologist, LLC*, to disclose my protected health information for the following purpose: **Transfer of my GYN care with Dr. Vanderlinde moving from Dover, NH to Newington, NH,** since the practice is closing and Dr. Vanderlinde is relocating.

Name of person or entity **receiving** information:

Dr. Teresa M. Vanderlinde, FACOG, CSC at
Dr. Colene Arnold, MD Gynecology & Associates
2299 Woodbury Ave. Suite 4 -1
Newington, NH 03801
Phone: 603-230-2433
Fax: 603-658-0938

Name of person or entity **releasing** information:

Dr. Teresa M. Vanderlinde, FACOG, CSC at
My Friend's Gynecologist, LLC
835 Central Avenue Suite 117
Dover, NH 03820
Phone: 603-516-0000
Fax: 603-516-5001

Information to be Disclosed:

_____ **Complete Medical Record**: This includes ALL below, as applicable, from the last 3 – 5 years, and other pertinent information Dr. Vanderlinde needs to continue my care from one practice to the next.

___ Progress Notes
___ All Visits/Exams
___ Pap Reports
___ Colpo Reports
___ Ultrasound Reports
___ Mammogram Reports
___ Lab Reports
___ Biopsy Reports
___ Radiology Reports
___ Culture Reports
___ Sexual Disease Testing
___ HIV Testing
___ Operative Reports *year?*_____
___ Hospital Records
___ Consult Reports
___ Previous Records
___ Psychiatric Records
___ Insurance and Demographic Info
___ Anything else on file needed for care

_____ Items I do **NOT** want transferred: ______________________________

_____ I understand that *My Friend's Gynecologist, LLC* will continue to care for me and treat me, until the practice closes on January 14, 2021, regardless of whether or not I sign this Authorization for Release.

_____ I authorize Dr. Colene Arnold to access my records, as needed to be involved in my care.

_____ I understand that this authorization may be subject to re-disclosure by the Receiving Health Care Agent for coordination of care, and may no longer be protected by Federal or State Privacy Laws.

_____ I understand that I may revoke this Authorization at any time, by informing *My Friend's Gynecologist, LLC*, in writing. This revocation will not include disclosures already made.

_____ I understand that I have a right to receive a copy of the information I am consenting to release.

_____ This Authorization will expire twelve (12) months from the date this form is signed, OR on this date I choose ____________________ OR for this reason ______________________________ .

____
Printed Name

____
Signature of Patient or Legal Representative

____
Date

____
Relationship to Patient