AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT'S NAME:_____ Date of Birth:_____

I, _____ Authorize Colene Arnold, MD Gynecology LLC to:

Disclose my health information to:

Name:_____

Address:_____

_____

Phone:_____

Obtain my healthcare information from:

Colene Arnold, MD Gynecology LLC

2299 Woodbury Ave, STE 4-1

Newington, NH 03801

Ph: 603-230-2433 Fax: 603-658-0938

Health information and records authorized to be disclosed:

[ ] A. All of my health care information, including without limitation, identifying information, personal and family history diagnosis, treatments, and medications from:

_____ to _____

Specific Beginning date of service Specific ending date of service

-OR-

[ ] B. The following specific health care information (Circle Desired Choices)

Evaluations Progress Notes Discharge Notes Treatment Notes Patient Intake Forms Billing Info

I authorize release of records pertaining to:

[ ] Mental Health [ ] Alcohol and/or Drug Abuse and/or [ ] HIV / Aids [ ] Psychiatric/Psychological Evaluation/Assessment [ ] Chemical Dependency Evaluation/Assessment

Purpose of Disclosure (Circle Desired Choices):

Continuity of care For insurance Purposes At the request of an attorney Transfer of Care

At the request of the undersigned individual Other (please specify):_____

Duration of Authorization: This authorization will remain in effect until:

Six months from today (___/___/___) One time request only

- I can revoke all or part of this authorization at any time by notifying Colene Arnold, MD Gynecology LLC in writing.
- I can refuse to disclose all or some of the information in my health care record
- A refusal to release some or all of the information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
- I may request an amendment of my medical records and understand that this request must be submitted in writing.

_____ _____ _____

PATIENT'S SIGNATURE SIGNATURE OF WITNESS DATE