Carol A. Pelletier
APRN, DNP, PLLC

505 West Hollis St Suite 106• Nashua NH 03062
Phone:603-577-1613 • Fax: 603-809-4934
www.carolpelletier.com

Patient Name: ________________________________ DOB: ________________
Phone#:____________Address:____

I AUTHORIZE Carol A Pelletier APRN, DNP and Kate A Nadeau APRN:
Release my Medical Records to: ____
(Name of Provider/Organization)
____
(Address)

Obtain my Medical Records from ____
(Name of Provider/Organization)
____

Check Confidential Information To Be Released or Obtained:
______ Problem List______ Laboratory Results______ Immunizations ______History and Physical
______ Consultation Reports ______ Medications ______ Progress Notes (Date)______ All Records
______ Other (Please Specify)

THE PURPOSE OF THIS INFORMATION IS FOR:
□ Transfer of Care □ Continuity of Care □ Attorney □ Insurance□ Other(PleaseSpecify)________________

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.
I understand that the revocation will not apply to my insurance company when the law provides the insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 90 days. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure
treatment.
TO THE EXTENT APPLICABLE, I UNDERSTAND THAT MY RECORD MAY CONTAIN INFORMATION THAT IS CONSIDERED SENSITIVE UNDER LAW. MY INITIALS BELOW INDICATE THAT I PERMIT INFORMATION OF THIS TYPE, IF IT EXISTS, TO BE RELEASED
______ Alcohol and/or Drug Abuse/dependency/diagnosis/treatment/referral*
______ HIV test results/AIDS related information/ (ARC) diagnosis and/or treatment
______ Diagnoses and/or treatment relating to other communicable diseases
______ Mental Health/diagnosis/treatment/referral

*This information has been disclosed to you from records protection by Federal Confidential Rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure(s) of this expressly permitted written consent of the person whom it pertains to or as otherwise permitted by 42 C.F.R. Part 2

____ ____________________
Signature of Patient Date

________________________________ ____________________
If Signed by Legal Representative, Relationship to Patient Signature of Witness