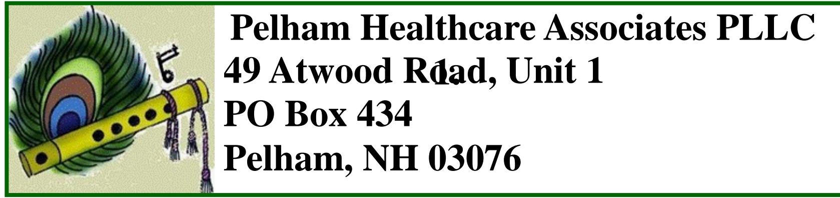

TEL: 603-635-2802 FAX 603-635-3070

I acknowledge having received a copy of Pelham Healthcare Associate's "Notice of Privacy Practices" and "Office and Referral Policies".

____________________________________ __________

Signature Date

____

Please Print Name

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _________________________________, hereby authorize Pelham Healthcare Associates PLLC to
(name)
disclose the following protected health information from the medical records to

my_______________________________, ______________________________, residing at
(relationship to recipient) (name of recipient)
____. I understand that information used
(address of recipient)
or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal and state law protecting its confidentiality.

____________________________________ __________

Signature Date

See other side