AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
(RELEASE OF INFORMATION)

I, _____ Date of birth: _____
Address: _____
authorize the use and disclosure of my protected health information (PHI) to:

Name: _____ Name: _____
Address:_____ Address:_____
_____ _____
_____ _____
Phone/Fax: _____ Phone/Fax: _____

I hereby authorize and request *Lucinda M. Fecteau, PhD, MAOM, OT/L* to release:
__Complete medical records __Other: _____
Reason for request:
__Consultation __Changing provider __Changed insurance __ Patient Request
Other: _____

I understand that I may revoke this authorization at any time by making my request in writing. This authorization will expire on _____ or 90 days from the date of this request.

Under federal guidelines, information about diagnosis and treatment of alcohol and/or drug abuse, psychiatric treatment and testing for HIV may not be released without specific authorization. Special authorization for release of information about treatment of anxiety and depression is not required. I authorize release of information concerning:

Initials: _____Drug and/or alcohol abuse and treatment
Initials: _____HIV testing and results
Initials: _____Psychiatric treatment

I have read and understand this authorization form. I understand that I am not required to sign this authorization as a condition of obtaining treatment or receiving services. I understand that there is the potential for re-disclosure by the recipient of the information. I understand that a fee may be charged for copies of records which are not sent directly to another medical provider. I release Lucinda M. Fecteau, PhD, MAOM, OT/L, Renaissance Wellness, Acupuncture and Integrative Medicine Associates of Nashua and all affiliates from legal responsibilities that may arise from the release of these records.

_____ _____ _____
Patient or Guardian Signature Patient or Guardian Printed Name Initials

_____/_____/_____ _____
Date Relationship to Patient