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**AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION
(MEDICAL RECORDS)**

Patient's Name: _____ Date of Birth: _____

Phone #: _____ Alternate #: _____

RELEASE RECORDS FROM: *(complete below and mail this form to the place you have listed)*

You are authorized and requested to release protected health information about the above named patient's care or copies of medical records in your possession.

*: All health care information and records. (General and Complete Release) *

: Health care information relating to the following treatment, condition or dates. (Limited Release)

I authorize the release of information regarding treatment of mental health conditions, drug or alcohol use, and treatment or testing for sexually transmitted diseases (including HIV/AIDS testing whether negative or positive).

Yes * **No**

*(*Recommended; If you do not select this, release of information may be substantially limited.)*

SEND RECORDS TO:

Anthony C. Zwaan, MD
Family Medicine
19 Hampton Road, Suite One
Exeter, NH 03833

◆ I understand this authorization may be revoked in writing at any time unless that information has already been disclosed prior to the date of revocation.

Signature: _____ Date Signed: _____
(Patient, Parent or Guardian) (Expires 6 month/180 days from this date)