ORCHARD MEDICAL GROUP
FAMILY MEDICINE

AUTHORIZATION TO REQUEST PROTECTED HEALTH INFORMATION

I authorize the following individual or entity to release the protected health information of the patient named below. I acknowledge that any information disclosed under this authorization may be subject to redisclosure by the recipient, unless otherwise restricted by law.

Patient Name: _____ **Date of Birth:** _____

Address: _____**City/Town:** _____

State: _____ **Zip Code:** _____ **Phone:** _____

Name of facility or person that now holds the records:

Facility Name: _____

Address: _____ **City:** _____ **State:** _____

Zip Code: _____ **Phone:** _____ **Fax:** _____

- **PLEASE TRANSFER RECORDS TO:** **ORCHARD MEDICAL GROUP**

____ **SALEM OFFICE**
159 N. Broadway, Salem, NH 03079
Phone: (603) 893-4119
Fax: (888) 927-0461

_____ **HAMPSTEAD OFFICE**
207 Stage Road, Hampstead, NH 03841
Phone: (603) 329-5222
Fax: (888) 927-0461

REPORTS REQUESTED:
HISTORY AND PHYSICAL _____ **OFFICE NOTES** _____
XRAY / IMAGING REPORTS _____ **OTHER** _____
LAB/PATHOLOGY _____

ALL OF THE ABOVE ___✓_____

HIGHLY CONFIDENTIAL INFOMATION:
MENTAL HEALTH _____ **ALCOHOL/DRUG USE** _____
HIV/AIDS _____ **SEXUALLY TRANSMITTED DISEASE** _____
OTHER _____

ALL OF THE ABOVE ___✓____

PURPOSE OF DISCLOSURE: MEDICAL CARE _✓__ **OTHER** _____

- **Note: This request will expire six months from the request date, unless otherwise noted.**

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
Name of Legal Representative **Relationship to Patient**