New Creation Healing Center, Inc.
80 Route 125
Kingston, NH 03848-3535
(603) 642-6700 office
(603) 642-6701 fax

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____, hereby authorize _____
(Patient name) (Name of physician, hospital or agency who has your records)
at _____ its employees
(Address) (City, state, zip code)
or agents to release copies of the medical records of _____
(Patient name)
to _____
(Name of physician, hospital or agency where you want them to go) (address, city, state, zip)

Check EACH BOX THAT APPLIES

Information to be released may include:

☐ Psychiatric

☐ Drug and or alcohol abuse

☐ HIV testing/AIDS information/Sexually transmitted diseases (STD)

The specific reports to be disclosed shall include:

☐ Complete record
☐ Consultation reports
☐ Labs, x-rays, diagnostic results
☐ Immunization records
☐ Progress notes
☐ Hospital reports
☐ Other (specify)
_____

I understand that this consent is revocable upon written notice to the above stated, except to the extent that action has already been taken on the authorization. Psychiatric, Alcohol, Drug, HIV and or AIDS, STD information, if present, will be disclosed only if authorized. This information is confidentially protected by Federal Law, which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted to such regulations. I further understand that I may select which information from the above list of confidential information will be released by checking off in the space provided.

_____ _____
(Patient or legal guardian signature in full) (Date of authorization, Expiration date or event)

_____
(Date of birth)

MAIL THIS FORM TO PREVIOUS PHYSICIAN

Revised 08/12