LONDONDERRY PEDIATRICS
25 Buttrick Road, Bldg. E
Londonderry, NH 03053

MEDICAL RECORD RELEASE

I hereby authorize you to release to:

_____
(Name of Physician, Clinic or Hospital)

_____
(Address)

The complete history in your possession. Records being transferred to another ***physician, clinic or hospital are free of charge, the first time***. If you the parent/guardian are requesting copies of the medical records we will follow the NH State Law, Chapter 85 rates of $15 for the first 30 pages and $.50 per page to complete the chart. If you request records which have been placed in storage (ours is off-site), you will be charged for the duplication of records at the NH State Law, Chapter 85 rate, of $15 for the first 30 pages and then $.50 per page, to complete the chart. In addition you will be charged the retrieval fee, plus shipping and handling. If the copies must be certified, you will be responsible for that additional cost. If you request the records be sent to you, the parent or guardian, the charges will be in accordance with the NH State Law, Chapter 85, as stated, even if it is the first request.

Patient's Name: _____ **DOB:** _____

Address: _____

Social Security Number: _____ **Telephone:** _____
(If available)

Signature _____ **Date:** _____
(Parent/Guardian)

Reason for transfer: Location _____

Office Concern _____

Other _____

May we call to discuss your concern? Yes/No

Best Telephone number to reach you? _____

I release ***Londonderry Pediatrics*** from all legal responsibilities, which may arise from the release of this information.

I hereby authorize you to release ***sensitive information such as abortion, substance abuse, mental health notes, venereal disease, rape and abuse.***

Signature _____ Date: _____
(Parent or Guardian)

I hereby authorize you to release ***HIV Testing***

Signature _____ Date: _____