Office of Family Nurse Practitioner Laura Hudson FNP-C
839 Central Ave. Suite 9 Dover, NH 03820
Phone: 603-749-0001. Fax: (603) 749-1006

Authorization to Exchange Protected Health Information

Patient Name: _____ DOB:_____
Other Last Names: _____ Phone: _____
Address: _____ _____

This will authorize my providers to use and/or disclose my protected health information for the following purpose:

_____

1. **Laura Hudson FNP-C** and her practice / representatives at 839 Central Ave suite 9 Dover, NH 03820 may _____ **Release** &/or _____ **Receive** my protected health information with / to / from:
   Initial (if applicable) Initial (if applicable)
2. **Provider:** _____ at Practice:_____
   at the following Address:_____
   Phone:_____ Fax: _____
3. **Provider:** _____ at Practice:_____
   at the following Address:_____
   Phone:_____ Fax: _____

Information to be Disclosed: *(Please* **initial correct option** *&/or* **check exactly what you want** *to be exchanged.)*

_____ **Complete Medical Record** (This includes, as applicable, information related to mental health, drug or alcohol treatment… genetic testing, STD testing, HIV/AIDS, and psychotherapy notes.)
Initial (if applicable)

_____ ***Complete medical record*** as outlined above, but at this time request that only my ***test results and imaging results be sent.***
Initial (if applicable)

OR _____ Records from the following dates: _____ to _____ .
Initial (if applicable)

OR _____ I want **ONLY** the following parts of my medical record to be disclosed: _____
Initial (if applicable) _____.

_____ I **DO NOT** want disclosed**:** _____ .
Initial (if applicable)

_____ I understand that *Laura Hudson* will continue to care for me and treat me, regardless of whether or not I sign this form.
Initial

_____ I understand that this authorization may be subject to re-disclosure by Laura Hudson to another Health Care Agent for coordination of care, and may no longer be protected by Federal or State Privacy Laws.
Initial

_____ I understand that I may revoke this Authorization at any time, by *informing Laura Hudson at the above address* in writing. A revocation will not include disclosures already made and if this Authorization is used to obtain insurance coverage, I may not have the right to revoke it because insurances require this information.
Initial

_____ I understand that I have a right to receive a copy of the information I am consenting to exchange.
Initial

_____ This Authorization will expire twelve (12) months from the date this form is signed, OR on this date I choose indicated below _____ OR for this reason _____.
Initial

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

_____ _____
Printed Name Relationship to patient if not patient