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<u>My Friend's Gynecologist, LLC ~ Dr. Terri Vanderlinde</u>
<u>& Primary Care for Women ~ Laura Hudson FNP-C</u>

Suite One 839 Central Ave. Dover, NH 03820 Ph: 603-516-0000 Fax: 603-516-5001

Protected Health Information Authorization to RELEASE Records

Patient Name: ______________________________ DOB:________________

Other Last Names: ______________________________ Phone: ________________

Address: ____

This signed form will authorize *My Friend's Gynecologist LLC & Primary Care for Women* to disclose my protected health information to <u>Compass Family Health LLC</u> at 839 Central Ave Suite 9 Dover, NH 03820.

***Information to be Disclosed:** *(Please **initial the correct option below** for what you want to be sent.)*

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

____ **Complete Record** as Above Except I do **NOT** want to disclose**:**__________

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_____ **ALL** testing results on file, and **ALL** appointment notes from visits with Laura Hudson FNP-C

I understand that *My Friend's Gynecologist LLC & Primary Care for Women* will continue to care for me and treat me, regardless of whether or not I sign this Authorization for Release of Records. I understand that this authorization may be subject to re-disclosure by the Receiving Health Care Agent for coordination of care, and may no longer be protected by Federal or State Privacy Laws.

I understand that I may revoke this Authorization at in time, by informing *My Friend's Gynecologist & Primary Care for Women*, in writing. This revocation will not include disclosures already made. If this Authorization is used to obtain insurance coverage, I may not have the right to revoke it since insurance requires this info.

I understand that I have a right to receive a copy of the information I am consenting to release.

This Authorization will expire twelve (12) months from the date this form is signed

____	____________________
Printed Name	Date
____	________________________
Signature of Patient or Legal Representative	Relationship to Patient (if not patient)