Dover Pediatrics
PEDIATRIC & ADOLESCENT MEDICINE

Authorization to Release Protected Health Information (PHI)

Patient's Name: _____ Patient's Date of Birth: ____/_____/_____

Parent's Name: _____ Parent's Phone: _____

Methods of Disclosure Authorized: Faxed, written, phone conversation, in-person, and/or secure e-mail.

Purpose of release: _____

For dates of care from: _____ **to** _____.
(beginning date) **(end date)**

I authorize Dover Pediatrics, PLLC to exchange (release to and obtain from) the patient's personal health information to the facility or person named below:

Name/Facility: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____ **Fax Number:** _____

Health Information to be Released, Obtained, and/or Discussed:

IMPORTANT! It is extremely important that you check DO or DO NOT for each item listed below. Please do not skip any item as it could impact our ability to fulfill your request.

I ☐ DO	☐ DO NOT	want **medical diagnostic, testing, and treatment** information disclosed.
I ☐ DO	☐ DO NOT	want **immunization and physical** records disclosed.
I ☐ DO	☐ DO NOT	want **sexually transmitted diseases and/or HIV/AIDS** information disclosed.
I ☐ DO	☐ DO NOT	want **behavioral/mental health** information disclosed.
I ☐ DO	☐ DO NOT	want **developmental/educational** information disclosed.
I ☐ DO	☐ DO NOT	want **alcohol/substance use** information disclosed.
I ☐ DO	☐ DO NOT	want **(specify)** _____ discussed/disclosed.

I understand this authorization is valid for ONE YEAR and may be revoked (withdrawn) at any time prior to the expiration date by notifying the practice in writing, except to the extent that Dover Pediatrics, PLLC has already used or disclosed the information in reliance on my authorization.

_____

Patient/Parent/Legal Representative's Signature Date

Phone: 603-742-4048 17 Old Rollinsford Rd. Dover, NH 03820 Fax: 603-743-3345