The Center for Bodies in Balance

REQUEST FOR RELEASE OF MEDICAL RECORDS

I, _____, authorize The Center for Bodies in Balance, LLC to disclose or obtain the following information from the health record of:

PATIENT NAME: _____
DOB: ____ / ____ / ____
ADDRESS: _____
_____
_____
PHONE: (_____) _____
MEDICAL RECORD #: _____

PLEASE RELEASE RECORDS FROM/TO:
NAME: _____
ADDRESS: _____
_____
_____
PHONE: (_____) _____
FAX: (_____) _____

Please check the items applicable for information to be disclosed. Covering the period(s) of health care from (date) _____ (date) _____.

__Complete Health Records
__ History & Physical
__ Consultation
__ Discharge Summary
__ Progress Reports
__ Other (Specify): _____

__ Laboratory Tests
__ Imaging Reports (X-Ray, MRI, EKG…)
__ Operative Reports
__ Procedure Reports

__ HIV Results
__ Mental Health
__ Drug / Alcohol
__ Pathology Reports

For the Purpose of :
__ Personal
__ Legal
__ Other (Specify): _____

__ Insurance
__ Treatment (Continuation of Care)

My evaluation, diagnosis and/or treatment relating to the conditions listed below may be released to the requestor identified above for the following type of records unless otherwise indicated:

_____ - AIDS or HIV infection
_____ - Psychiatric care and/or psychological assessment
_____ - Treatment for alcohol/or drug abuse
_____ - Mental Health Treatment

This authorization may be revoked in writing at any time. This authorization will otherwise expire in 6 months from date of signature, unless specified otherwise here _____. Your information may be transmitted by fax, electronically, verbally or by mail. **I understand that there may be a fee for this service.**

Patient's Signature: _____ Date: _____
(Parent, Legal Guardian or Appropriate Consenting Party)
Relationship to Patient: _____

Please send records to:
The Center for Bodies in Balance, LLC.
Correspondence Address: 1 Greenleaf Woods Drive, Suite 101, Portsmouth, NH 03801
Phone: (603) 319-8334 Fax: (603) 431-2940