CAARD
CENTER FOR ASTHMA, ALLERGY AND RESPIRATORY DISEASE, PLLC

Mark R. Windt, M.D.

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient name: _____ DOB: ___/___/___

Address: _____

_____

Phone: _____

I authorize to disclose/release the following information (check all applicable)
Please give specific dates: from _____ to _____

☐ All records
☐ Abstract/Summary
☐ Laboratory/pathology records
☐ Pharmacy/prescription records
☐ X-ray/radiology records
☐ Sensitive health info.
(i.e. mental health, HIV/AIDs test results, sexually transmitted disease) _____

_____

Please send the records listed above to:

Name: Center for Asthma, Allergy and Respiratory Disease, PLLC
Address: 65 Lafayette Road
North Hampton, NH 03862
Phone: 603-964-3392 Fax: 603-964-3396

*This authorization will remain in effect for **one year** from the date of signature below, unless you specify a different date here: _____ (date). You or your personal representative may revoke this authorization at any time by providing written notice as specified in our Notice of Privacy Practices; however, your revocation will not apply to any previously released information.*

Signature

_____ _____
Signature of patient or patient's representative | Date

_____ _____
Printed name of patient representative | Representative's authority to sign for patient, (i.e. parent, guardian, power of attorney for healthcare, executor)

65 Lafayette Road • North Hampton, NH 03862-2480 • Phone: (603) 964-3392 • Fax: (603) 964-3396