

My Friend's Gynecologist, LLC ~ Dr. Terri Vanderlinde

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REQUEST to RECEIVE PROTECTED HEALTH INFORMATION

PLEASE FAX TO 603-516-5001 ☺ THANK YOU VERY MUCH!

FROM: Dr. _____

FROM: Dr. _____

Address _____

Address _____

Phone _____

Phone _____

Fax _____

Fax _____

___ **Progress Notes**

___ **Lab Reports**

___ **Operative Reports** (year _____)

___ **All Visits**

___ **Biopsy Reports**

___ **Hospital Records**

___ **Pap Reports**

___ **Radiology Reports**

___ **Consult Reports**

___ **Colpo Reports**

___ **Culture Reports**

___ **Previous Records**

___ **Ultrasound Reports**

___ **Sexual Disease Testing**

___ **Psychiatric Records**

___ **Mammogram Reports**

___ **HIV Testing**

___ **Anything Else on File**

Patient _____

Other Last Names _____

Date of Birth _____

Social Security _____

Phone Number if Questions _____

Other Info _____

_____ Release ALL of my Protected Health Records IN FULL to include ALL of the above items.

_____ Release PART of my Protected Health Records pertaining to ONLY the checked items above.

_____ Release PART of my Protected Health Records from Date _____ to _____

_____ Release PART of my Protected Health Records for the treatment of _____

I, _____, am the patient / legal guardian who has authorization to release the above records. This form gives my health care providers permission to share my private information and discuss the details of my case as needed. Unless otherwise stated, my permission expires TEN (10) years from the date of signing. All my questions have been answered. Expires _____.

Patient (or Guardian ~ Relationship _____)

Date