

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

Suite One 839 Central Ave. Dover, NH 03820 Ph: 603-515-0000 Fax: 603-516-5001

REQUEST to **RELEASE** PROTECTED HEALTH INFORMATION

**TO:** Dr. \_\_\_\_\_

**TO:** Dr. \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

Fax \_\_\_\_\_

Patient \_\_\_\_\_

Other Last Names \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security \_\_\_\_\_

Phone Number if Questions \_\_\_\_\_

Other Info \_\_\_\_\_

- Progress Notes
- All Visits/Exams
- Pap Reports
- Colpo Reports
- Ultrasound Reports
- Mammogram Reports

- Lab Reports
- Biopsy Reports
- Radiology Reports
- Culture Reports
- Sexual Disease Testing
- HIV Testing

- Operative Reports year \_\_\_\_\_
- Hospital Records
- Consult Reports
- Previous Records
- Psychiatric Records
- Anything Else on File

\_\_\_\_\_ 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 from *MFG*. 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