



In affiliation with Orchard Medical Group

Enhanced Primary Care

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH/MEDICAL RECORD INFORMATION

I hereby authorize the following to disclose the protected health information of the patient listed below. I understand that the information used or disclosed pursuant to this authorization could be subject to be redisclosed by the recipient, unless prohibited by law.

Patient Name : \_\_\_\_\_

Date Of Birth : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Current Address : \_\_\_\_\_

Phone Number : \_\_\_\_\_ SSN : \_\_\_\_\_

## NAME OF FACILITY OR PERSON THAT NOW HOLDS THE RECORDS:

Name : \_\_\_\_\_

Address : \_\_\_\_\_

Phone Number : \_\_\_\_\_ Fax # : \_\_\_\_\_

## PLEASE TRANSFER RECORDS TO:

Delphi Enhanced Primary Care - Fax #: 888-927-0461 - 20 Washington Place Suite 3, Bedford NH 03110

Reports Requested :  History and physical  Labs / Pathology  
 Xray / DI Reports  Office Notes Other \_\_\_\_\_  
 All of the Above

Highly Confidential Information :  Mental Health  Alcohol / Drug Abuse Other \_\_\_\_\_  
 AIDS / HIV  Sexually Transmitted Diseases  
 All of the Above

Purpose of Disclosure :  Medical Care  Other

Note: This request will expire six months from the request date, unless otherwise noted.

\_\_\_\_\_  
Signature of Patient or Legal Representative

Date : \_\_\_\_\_

\_\_\_\_\_  
Name of Legal Representative

\_\_\_\_\_  
Relationship to Patient