Franklin Pierce Health Services
40 University Drive
Rindge, NH 03461
Phone 603-899-4130
Fax: 603-899-1050

AUTHORIZATION FOR RELEASE OF INFORMATION

Please complete form thoroughly. Your medical records cannot be released until this form is completed and signed by the student.

PLEASE COMPLETE EACH STEP ON THE FORM

STEP 1: Information about Patient: PLEASE PRINT!!

Patient Name:_____
Last First

Date of Birth:_____ Student ID #: _____

Address:_____
Street City State Zip Code

Phone#: _____ Last Date Attended Franklin Pierce _____
_____

STEP 2: Who has the records now? PLEASE PRINT!!

I hereby authorize:
Name of Provider / Practice:
_____

Provider Address:
_____

Phone#: _____ Fax#: _____

STEP 3: Requested Information: PLEASE PRINT!!

The information I would like released is:_____

_____

Step 4: Release the information to: PLEASE PRINT!!

Name of Provider / Practice / Parent / Student: _____

Address: _____

Phone #: _____ Fax #: _____

STEP 5: Your signature: REQUIRED FOR RELEASE

This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for disclosure beyond recipient is required.

Student Signature:_____ Date: _____

Written: 9/00
Revised 2/02, 1/03, 10/05, 5/06, 5/07, 6/08, 11/13