MANCHESTER-BEDFORD MYOSKELETAL
A New Hampshire Limited Liability Company

Tel. (603) 622-1112
Fax. (888) 965-6870

AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ________________________________ DOB: ______________________________________

Address: ____________________________________ Tel. _______________________________________

City, State, Zip: ____

I authorize Manchester-Bedford Myoskeletal LLC to ☐ **Release** And/or ☐ **Obtain** my Protected Health Information to/from the following:

Dates of Service: _______________________________ To: __________________________________

Organization: ____

Contact Name: ____________________________________ Department: ______________________________

Address: ____

Tel.: ____ Fax: _______________________________________

Records Requested:

☐ X-rays ☐ MRIs ☐ Radiology Reports ☐ CD/DVD if available

☐ Prescription ☐ Diagnosis ☐ Physicians Clearance for Myoskeletal Treatment (See info attached)

☐ Chart Notes ☐ Assessment ☐ Re-Evaluation ☐ All Records

☐ Other (specify): ____

Purpose of Release:

☐ Continuation of care/Physician Referral ☐ Worker's Comp ☐ Auto Insurance ☐ Attorney / Legal case

☐ Attending Physician's records ☐ Other: ____

I authorize the release of my medical records and/or other protected health information as described above. This authorization expires 90 days from date signed below unless otherwise indicated:

______________________________	______________	______________________________
Patient/Representative Signature	Date	Relationship to Patient
______________________________	______________	______________________________
Clinic Manager	Date	Alternate Expiry

Pursuant to NH Title XXX, Ch 332-I (2015), the fee for copies is $15.00 for the first 30 pages and $.50 for every page thereafter

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