Dr. J.P. Michaud, O
Dr. Amy Michaud, OD

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Phone: 603-497-3622 Fax: 603-497-5325

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

_____ _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

ATTN: _____ Phone: _____ Fax: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature: _____ Date Signed: _____

Printed Name: _____ _____

If you are signing as a personal representative of the patient: Relationship to Patient:_____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED