Sage Integrative Medicine
92 Portsmouth Ave, Suite 10
Exeter, NH 03833
Phone: 603-583-4780
Fax: 603-821-0273

Patient: _____ Date of Birth: _____

Address: _____

Requesting records from: _____

Please check off items:

Progress Notes [] History & Physical Exams [] Diagnostic Reports [] Lab Data/Reports []

Operative/Procedure reports [] Consults [] Other [] _____

Release to: Sage Integrative Medicine, Marney Roemmelt, MD
92 Portsmouth Ave, Suite 10
Exeter, NH 03833

Dates of Care Included: _____

For the Purpose of: [] Personal []Insurance []Attorney []Physician []Other _____

I understand that information may be released by any acceptable means, including by fax.
I understand that Sage Integrative Medicine will not condition treatment on my providing this authorization and that I may refuse to sign this authorization, unless the treatment involves research or is performed only for the purpose of creating protected health information for disclosure to a third party (such as an insurance physical).
I understand that the recipient of information disclosed under this authorization may re-disclose this information, and the information may no longer be protected by federal or state confidentiality laws.
I understand that New Hampshire law permits a practice to charge for the cost of copying the information released under this authorization, up to $15.00 for the first 30 pages or $.50 per page, whichever is greater. Charges for copies of filmed records (such as x-rays) will be at a reasonable cost.

It is my understanding that this information will be used or disclosed only for the purpose described above. I understand that I may revoke my authorization at any time by written notice delivered to the practice's medical information department, except to the extent that the practice already has used or disclosed information in reliance on my authorization.

EXPIRATION DATE: This authorization will expire on (date) _____ or (event) _____

Date: _____ Signature _____ Print Name _____

If not signed by patient, indicate authority or relationship: _____

Date: _____ WITNESS Signature _____ Print Name _____