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**Authorization to Release Protected Health Information**

1. I hereby authorize New Hampshire Hand Therapy Center, Inc. to use or disclose personal protected health information from the medical records of the patient listed below.

2. Patient Information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone: \_\_\_\_\_

3. Information to Be Disclosed To:

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

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

4. The above information is to be used for the following purpose(s):

Legal  Insurance  Employer  Case Manager/ Adjuster  Other\*

\*If Other, please specify:

\_\_\_\_\_  
\_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_