ACTIVE CHOICE HEALTHCARE
ERIC KROPP, MD

13 Chenell Drive, Suite 2, Concord, NH 03301
Ph: (603) 410-4644 Fax: (603) 499-7995

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Information:

Name: _____ Date of Birth: _____

I authorize _____ to:

☐ **Send / disclose to:** ☐ **Receive information from:**

Name: _____ Ph:_____

Address: _____ Fax:_____

_____

_____

Purpose of Communication: _____

Information to be shared: _____

_____

This authorization will expire in one year from signature or on _____.
You have the right to revoke this authorization, in writing, at any time before it ends. This will not apply to any information previously released.

I Understand that:

- I have been offered a copy of this authorization.
- I am not required to sign this release in order to receive treatment.
- Upon request, I may inspect or obtain a copy of the information I am authorizing to be released, and that a reasonable fee may be charged to cover processing costs of this request.
- Information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state laws.
-This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, AIDS or AIDS-related illness, sexually transmitted infection, and/or HIV test results unless I limit the disclosure to *exclude* the following: _____

_____

Signature of Patient/Representative: _____ **Date**: _____

(If signed by person other than the patient, print name and state relationship and authority to do so):

Print Name: _____ Relationship: _____

Patient is: ☐ Minor ☐ Incompetent / Incapacitated ☐ Deceased

Legal Authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Durable Power of Attorney for Healthcare