Commonwealth Labs

ANNEX 1

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please print

_____

Patient Name | Other Last Names

_____

Date of birth | Phone Number | Email Address

_____

Street Address | City, State, Zip code

I hereby request that Morgan Records Management LLC, 159 Frontage Rd, Manchester NH 03103 provide the above-referenced patient (or patient's representative) with access to the following records.

Type of Lab Results: _____

Year or Date of Testing _____

Please send records by one of the following delivery methods:

☐ Secure HIPAA approved electronic transfer to the following email address.
List your email address here _____

☐ Pick up disc, in person, at Morgan Records, 159 Frontage Road, Manchester, NH 03103. Available office hours are Monday – Thursday 8am-4pm. A 48 hour notice for pick up is required.

☐ Disc mailed to patients home. List address here if different from above:

_____

I, _____, am the patient or legal guardian who has authorization to release the above records. Any facsimile, copy, or photocopy of this release will be valid for 90 days and shall authorize you to forward my medical records. This form gives my health care providers permission to share my private information and discuss the details on my case, as needed. Only records from this facility can be legally released. Any records from other facilities must be obtained from them directly.

_____

Patient or Legal Guardian Signature | Date

Your completed authorization form may be faxed to 603-509-3987, emailed to Marie@MorganRM.com, or mailed to Morgan Records Management LLC, 159 Frontage Rd, Manchester, NH 03103.