

Dr. Avrohm Melnick

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 _____

Transfer of care is required due to the closing of my physician's office. Therefore, I hereby authorize

Morgan Records Management LLC, 159 Frontage Rd, Manchester, NH 03103,

on behalf of **Dr. Melnick, 2000 Washington St, #570, Newton, MA 02462** to execute one of the following:

Records are processed in the order they are received and can take up to 30 business days.

Please select one of the following delivery options:

Secure HIPAA approved electronic transfer to patient.
List your email address here _____

Disc mailed to home or physician. There will be a **\$10 shipping charge prior to mailing**. We mail USPS Certified Return Receipt. *List address here:*

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 you permission to share my private information obtained from this facility. Only records from this facility can be legally released. Any records from other physicians must be obtained from them directly.

Please note; a \$25 records management fee is requested to process & deliver your medical records.

Payment Options:

- **CREDIT CARD** – visit our website at MorganRecordsManagement.com to pay online
- **CHECK** - please mail your completed authorization form with an attached check or money order made payable to Morgan Records Management LLC, to 159 Frontage Rd, Manchester, NH 03103.

Patient or Legal Guardian Signature _____ Date _____

Your completed authorization form may be faxed to 603-606-1126, emailed to Medical@MorganRM.com, or mailed to Morgan Records Management LLC, 159 Frontage Rd, Manchester, NH 03103.