AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

_____
Date

I,_____
(Last Name, First, M.I. or Maiden Name)

of _____
(Address)

_____
(Date of Birth) (Social Security No.)

hereby authorize and request _____
(Name of doctor/therapist at Woodland Professional Associates)

to release to/exchange with _____
(Name of individual or agency)

_____
(Address of individual or agency)

the following information:
_____

_____ for the following purpose: _____

_____

The protection of the confidentiality of information contained herein is required under Chapters 329 and 330 of the laws of the State of New Hampshire. By signing this release, I acknowledge my permission to release/exchange only the specified information to the individual/ agency I have named.

_____ _____
Witness Signature (Please state if parent or guardian)

_____ _____
Relationship Date Signed

Woodland Professional Associates ♦ 3 Executive Park Drive Suite 201♦
Bedford NH 03110
786.265.8615 ♦ 877.232.7416 fax

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