Kelly DeFeo FNP-C, CR.NA, PhD

Zachary Chase, CRNA, APRN

Kevin Larochelle, APRN, FNP

Mailing Address:
Cranmore Health Partners
Po Box 125
Center Conway NH, 03813

Phone: 603 730 5356 **Fax: 603-730-5477**

CRANMORE HEALTH PARTNERS
Primary, Pain, and Urgent Care

Person or facility to whom Records are being released/requested: _____

Address: _____ City/Town: _____ State: _____ Zip Code: _____

Patient Full Name: _____ Date of Birth: ____/_____/_____

Patient Address:_____ City/Town: _____ State: _____ Zip Code:_____

I, hereby, authorize the person/facility named above to release/request copies of my records including:

_____ Complete Records	_____ Medication Lists	_____ Radiology Reports
_____ Discharge Summaries	_____ Progress Notes	_____ Lab Results
_____ Pathology Reports	_____ EKG's	_____ Operative Reports
_____ Emergency Dept. Reports	_____ Other	

Purpose: _____ Further Medical Follow-Up _____ Continuation of Care

**I understand my medical records may contain information regarding treatment and/or referral for alcohol/substance abuse or psychiatric care and authorize the release of this information to the above-named person/facility. I further understand that federal regulations prohibit redisclosures of this information by receiving person/facility without my specific consent.*

Patient's signature: _____ **Date**: _____

The above individual is unable to consent because: _____ Minor _____ Incapacitated
_____ Deceased (proof of Admin. of Estate required) _____ Other

Therefore, I consent on behalf of the named above: Representative's signature: _____ Date: _____
Relationship to Patient: _____ Witness signature: _____ Date: _____