Discover Health
Functional Medicine Center

T Murray Wellness Center, Inc
24 Pleasant Street / P.O. Box 244 Conway, NH 03818
Phone (603) 447-3112 Fax (603) 447-3118

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL RECORDS

_______________________________________ ___________________
Patient Name (Please Print) Date of Birth

I hereby authorize Patricia Murray, DO to obtain/release records (Please circle one) from/to:

Physician/Other: ____

Address: ____

__________________________ _____________________________ ______________________
City/Town State Zip Code

Phone: _________________________________ Fax: ______________________________________

____
Specific Information to be released

I Understand that my medical records could possibly contain information related to the diagnosis or treatment of one of the following conditions:

- Psychological or Psychiatric Problems
- Substance Abuse or Chemical Dependency
- Sexually transmitted disease or HIV infection or testing

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I Authorize release of the requested information to me only so that I may protect any sensitive information that they may contain.

☐ I authorize the release of the requested records directly to the party who requested this information regardless of content.

I’ve read this release and understand the information contained in this document. I understand that I may revoke this consent at any time except that the action has been taken reference to this request. I can also revoke this consent with proper notification of Patricia Murray, DO at any time this release is valid for this request only.

This Authorization will expire on (date or event) _______ If no date or event is stated, expiration is 60 days from the date this release was signed.

Signature of Patient or Legal Guardian: ____

Witness: ____ Date: _____________________________