



Authorization to Exchange Information
Pediatric Associates of Hampton and Portsmouth, P.C.

330 Borthwick Ave, Suite 101 Portsmouth, NH 03801

Patient Name _____ DOB _____

I authorize *Pediatric Associates of Hampton and Portsmouth* to:

_____ Gather information from _____ Exchange information with

Name of person or practice: _____

Phone Number: _____ Fax Number: _____

Address: _____

The authorized information includes (check all that apply):

___ Intake/Treatment/Discharge Summaries ___ Mental Health

___ Office/Progress Notes ___ Labs/radiology

___ Complete medical records for transfer of care into Pediatric Associates

Other: _____

I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically one year after the date on this request.

If you have any further questions or concerns, please contact the office.

Phone – 603.436.7171 Fax – 603.433.5931

For sending Medical Records – DO NOT FAX, please mail paper copy or print off digital file and bring into office. Our machine cannot accept large faxes, thank you for understanding

Patient or Guardian Signature _____ Date _____

Patient or Guardian printed name _____