Morgan Records Management HIPAA Medical Release Form
Altrix Primary Care - Nashua

Please print:

Patient Name | Other Last Names

Date of birth | Phone Number | Email Address

Street Address | City, State, Zip code

I hereby authorize **Morgan Records Management LLC, 8 State Street, Nashua, NH 03063**, on behalf of the provider listed above to execute one of the following:

Please select one of the following delivery options (we are unable to provide paper or faxed copies):

☐ Secure HIPAA approved electronic transfer **$35**: ***List email you want chart sent to here*:**

_____

☐ USB Drive mailed **$55**. We mail USPS Certified Return Receipt. ***List address you want disc mailed to 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.

- **TO REQUEST ONLINE AND PAY BY CREDIT CARD, DO NOT USE THIS FORM** – please use our online form: MorganRecordsManagement.com-> Patient Records Requests -> Request My Medical Records
- **CHECK** - please mail your completed authorization form with an attached check or money order made payable to Morgan Records Management LLC, to 8 State Street, Nashua, NH 03063.

_____

Patient or Legal Guardian Signature | Date

Patients over the age of 18 must sign. If a patient is unable to sign that is over the age of 18, legal documentation must accompany this release form.

Your completed authorization form may be emailed to Medical@MorganRM.com. We will send you an invoice with payment due upon receipt. The completed authorization may also be mailed to Morgan Records Management LLC, 8 State Street, Nashua, NH 03063 with a check for the payment amount based on your selection above. Requests are processed in the order that they are received and will be delivered based upon your delivery selection within 30 business days or on the requirements by state law as long as we have full access to the records from the doctor/facility listed above. There is usually a transition period between the time an office closes and we have full access to their medical records.

MEDICAL DISCLAIMER: 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. I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.