INSIGHT MEDICAL GROUP LLC.

AUTHORIZATION TO RELEASE/ EXCHANGE PROTECTED HEALTH INFORMATION to and between Insight Medical Group LLC and another entity

_____
Date

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

of _____
(Address)

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

hereby authorize and request _

Insight Medical Group LLC. &, Robert E. Dillon, PMHNP/FNP

of 861 Lafayette Rd, Unit 8, Hampton, NH. 03842 fax 888-979-8717 :

to release or to exchange information with :
(person or entity of patient's choice, Physician, NP, Lawyer, Therapist, etc.,):

_____

_____

_____

*** protected health information pertinent to collaborative treatment, defense or referrals; related to medical, legal or mental health issues, or the treatment of substance abuse disorders. This may include any laboratory testing .**

_____
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The protection from disclosure of protected confidential information is required under Federal Confidentiality Laws (42 CFR Part 2 and 45 CFR Parts 160-164) and Chapters 329 and 330 of the laws of the State of New Hampshire. By signing this release, I acknowledge my permission to release/ exchange all or part of my treatment and/or pertinent healthcare operations. **This release may include records containing information regarding diagnosis and treatment of mental illness and/or substance abuse. This permission will persist for 12 months from this date, and may have already been been duplicated in the patient treatment agreement.**

_____ _____ _____
Patient Signature (Please state if parent or guardian) date

_____ _____
witness Date

release.doc