

**Anthony C. Zwaan, MD**  
**Family Medicine**  
**19 Hampton Road, Suite One, Exeter, NH 03833**  
**Tel. 603-773-2225 Fax 603-658-3105**

**AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION  
(MEDICAL RECORDS)**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone #: \_\_\_\_\_ Alternate #: \_\_\_\_\_

RELEASE RECORDS FROM: *(complete below and mail this form to the place you have listed)*

**EXETER FAMILY MEDICINE ASSOCIATES**

**9 BUZELL AVENUE**

**EXETER, NH 03833**

You are authorized and requested to release protected health information about the above named patient's care or copies of medical records in your possession.

\*: All health care information and records. (General and Complete Release) \*

: Health care information relating to the following treatment, condition or dates. (Limited Release)

I authorize the release of information regarding treatment of mental health conditions, drug or alcohol use, and treatment or testing for sexually transmitted diseases (including HIV/AIDS testing whether negative or positive).

**Yes \***  **No**

*(\*Recommended; If you do not select this, release of information may be substantially limited.)*

SEND RECORDS TO:

**Anthony C. Zwaan, MD**  
**Family Medicine**  
**19 Hampton Road, Suite One**  
**Exeter, NH 03833**

◆ I understand this authorization may be revoked in writing at any time unless that information has already been disclosed prior to the date of revocation.

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
(Patient, Parent or Guardian) (Expires 6 month/180 days from this date)