City of Nashua
Division of Public Health and Community Services
Asthma Education and Outreach Program

Release and Exchange of Confidential Information

I hereby authorize an exchange of information regarding my child's demographics, health insurance status, and doctor, as well as any important medical information regarding my child's asthma between the Nashua Health Department and:

☐ Dartmouth-Hitchcock Health	☐ Nashua Pediatrics	**Specify Other:**
☐ Lamprey Healthcare	☐ Southern NH Health	
☐ Nashua Health	☐ St. Joseph Health	

Name of Provider Making this Referral: _____

Phone:_____ Fax: _____

Address: _____

(Please Print)

Patient Name [Last, First, Middle]	Date of Birth	M / F	Parent / Guardian Name [Last, First, Middle]
	/ /		

Street Address City	Apt #	Zip Code

Home Phone Number	Work or Mobile Phone Number	E-mail (if available)
( )	( )	

Best day(s) and time(s) to call you: M. _____ am / pm T._____ am / pm W. _____ am / pm TR._____ am / pm F._____ am / pm

School Your Child Attends	School Nurse	Grade

Primary Language Spoken at Home?				
English	**Spanish**	**Arabic**	**Bosnian**	**Other:**

Health Insurance Status	Primary Care Provider
YES; Type:	**YES; Name:** **Location:**
NO Health Insurance	**NO Primary Care Provider**

I consent to release of the above information to the City of Nashua, Division of Public Health and Community Services Asthma Education and Outreach Program. I further authorize the City of Nashua, Division of Public Health and Community Services to share this information with health care providers and other social service agencies to which my child may be referred. I understand that a representative from the Asthma Education and Outreach Program will be contacting me directly to officially enroll my child in this program. I also understand that a representative from the Asthma Education and Outreach Program may contact my child's primary care provider and/or school nurse throughout the one-year term of this agreement for further asthma case management. I understand this release may be revoked at any time with a written request. I understand I may request a copy of this signed release. This authorization is in effect for 1 year from date of signing.

Signature of Parent/Legal Guardian: _____ Date: _____

FAX or MAIL this Form and Other Pertinent Information to:

Please mail all correspondence to:

City of Nashua Division of Public Health and Community Services
18 Mulberry Street, Nashua, NH 03060

Please fax or call Public Health Nurses:

Community Health Department Fax: (603) 594-3323 Phone: (603) 589-4500