AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete form thoroughly. Your medical records cannot be released until this form is completed, signed by the patient or legal guardian and returned to (978-691-5693). There may be a processing fee associated with this request.

AS YOU COMPLETE EACH STEP ON THE FORM, PLEASE MAKE A CHECK MARK IN THE BOX PROVIDED AT LEFT.

Step 1 Completed ☐

STEP 1: *Information about you:* **PLEASE PRINT!!**

PATIENT NAME: _____ DATE OF BIRTH: _____

Last First

ADDRESS: _____

Street City State Zip

Step 2 Completed ☐

STEP 2: *Who has the records now?* **PLEASE PRINT!!**

I hereby authorize: _____ MD / DMD (Circle One)

PHYSICIAN'S _____

ADDRESS: _____

Step 3 Completed ☐

STEP 3: *To whom do you wish to release your records?* **PLEASE PRINT!!**

To release the following information: Please specify:

☐ ALL RECORDS OR

☐ Dates of Treatment: ___ TO _____ OTHER: _____

TO:

Step 4 Completed ☐

STEP 4: *Your signature:*

This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for redisclosure beyond recipient is required.

___ _____

Date Patient's signature

_____ _____

Witness Signature Parent / Guardian's signature

Step 5 Completed ☐

STEP 5: *Release for Sensitive Information:*

I UNDERSTAND THAT IF MY MEDICAL RECORD CONTAINS INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, VENEREAL DISEASE, SOCIAL SERVICE, HEPATITIS B TESTING/ TREATMENT, AND/OR SENSITIVE INFORMATION, I AGREE TO ITS RELEASE.

_____ _____

Signature of Patient or Legal Guardian Date

Step 6 Completed ☐

STEP 6: *Release of HIV Information:*

IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV (AIDS) TESTING AND/OR TREATMENT RECORDS RELEASED YOU MUST SIGN AND DATE ON THE LINE BELOW:

I AGREE TO THE RELEASE OF THIS INFORMATION.

_____ _____

Signature of Patient or Legal Guardian Date