AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

851 MIDDLE STREET
FALL RIVER, MA 02721
508-324-6800
FAX 508-324-6828

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 our office. 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

DAYTIME TELEPHONE _____

STEP 2 COMPLETED ☐

STEP 2: Reason for requesting your medical records (please check one)**:**

☐ TRANSFER OF CARE ☐ COORDINATION OF CARE ☐ OTHER (Please explain) _____

STEP 3 COMPLETED ☐

STEP 3: Who has the records now? **PLEASE PRINT!!**

I hereby authorize: _____

Physician's Address: _____

STEP 4 COMPLETED ☐

STEP 4: To whom do you wish to release your records? **PLEASE PRINT!!**

To release the following information: Please specify:

☐ ALL RECORDS OR

☐ DATES OF TREATMENT _____ OTHER _____

RELEASE TO: _____ MD/DO (circle one)

ADDRESS: _____

STEP 5 COMPLETED ☐

STEP 5: 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.

_____
PATIENT'S SIGNATURE

_____ _____
WITNESS SIGNATURE PATIENT/GUARDIAN'S SIGNATURE

STEP 6 COMPLETED ☐

STEP 6: 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 7 COMPLETED ☐

STEP 7: Release of HIV Information:

IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV (AIDS) TESTING/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

Purpose for the release of my medical records:

☐ INSURANCE CHANGE ☐ CONSULTATION / 2ND OPINION ☐ MOVING OUT OF THE AREA

Dissatisfaction with physician or clinical care: (please explain) _____

_____

_____

_____

_____

Dissatisfaction with staff services: (please explain)_____

_____

_____

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_____

Other: (please explain)_____

_____

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