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MEDICAL RECORDS RELEASE FORM

Medical Record #: _____ Date of Birth: _____

Patient Name: _____

Address: _____

City, State & Zip Code: _____

Phone #: _____

RECORDS TO BE DISCLOSE TO:

Name of Person or Facility: _____

Practice Address: _____

City, State & Zip Code: _____

Phone #: _____ Fax #: _____

Please select all the specific documents that apply to your request:

- ☐ Office Notes
- ☐ Radiology Reports
- ☐ Lab Reports
- ☐ Entire Health Record
- ☐ Pathology Reports
- ☐ Colonoscopy Reports
- ☐ Endoscopy Reports
- ☐ Other: _____

Please place your initials beside the options below to authorize the release of sensitive information pertaining to:

Mental Health: _____ HIV/AIDS /Other Infectious Diseases: _____
Genetic Testing: _____
Drug or Alcohol: _____ Not Applicable: None of these apply: _____

Please select the purpose of your request:

- ☐ Transition of Patient Care
- ☐ Attorney/Legal
- ☐ Insurance
- ☐ Social Services/Disability
- ☐ Worker's Compensation
- ☐ Personal
- ☐ Other: _____

Please select how recipient is to receive your records:

☐ Mail to address above ☐ Pick up at Practice ☐ Fax to number listed above

I understand and agree that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting the main office at the 189 Quincy St., Brockton, MA 02302, attention privacy officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provider research related treatment).

_____	_____	_____
Patient Signature	**Print Name**	**Date**
_____	_____	_____
Authorized Signature to sign for Patient	**Print Name**	**Date**

_____
Relationship to Patient

Rev: October 2023