



MEDICAL RECORDS RELEASE FORM

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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:

- | | |
|---|--|
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Colonoscopy Reports |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Endoscopy Reports |
| <input type="checkbox"/> Entire Health Record | <input type="checkbox"/> 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:

- | | | |
|---|--|------------------------------------|
| <input type="checkbox"/> Transition of Patient Care | <input type="checkbox"/> Attorney/Legal | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Social Services/Disability | <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Personal |
| <input type="checkbox"/> 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

189 Quincy Street
 Brockton, MA 02302-2895
 (508) 588-6700
 Fax (508) 584-3010

35 Summer Street
 Taunton, MA 02780
 (508) 821-4100
 Fax (508) 822-2367

One Donald's Way, Ste. 203
 East Bridgewater, MA 02333
 (508) 456-8021
 Fax (508) 378-2070