Authorization for Release of Medical Information

Please complete the form thoroughly. Your medical records cannot be released until this form is completed, signed by the patient or legal guardian and returned to this office.

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| Step 1  Please Print | Information about you:  Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Step 2  Please Print and give us as much information as you may know. | Who has the records now?    I hereby authorize: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Step 3  This Section has been completed for you. | To whom do you wish to release your records?  Please send my records to: Merrimack Family Medicine  600 Clark Road, Suite 3  Tewksbury, MA 01876  Phone: 978-851-4141  Fax: 978-640-9840 |
| Step 4  Please read thoroughly. Sign and date. | This authorization will expire 12 months from the date it was signed and may be revoked at any time in writing prior to the expiration date. Additional authorization for disclosure beyond recipient is required.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient Signature/Legal Guardian Date |
| Step 5  Please read thoroughly. Sign and date. | 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, HIV/AIDS testing and/or treatment, and/or any other sensitive information, I am agreeing to the release of this information.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient Signature/Legal Guardian Date |