AUTHORIZATION TO RELEASE INFORMATION
(Please submit to provider where record copies are being requested)

I hereby authorize _____to release the following information from the medical record of:

Name: _____ Date of Birth: _____
Address: _____ Social Security #: _____
_____ Tel #: _____

Medical Record is to be released to (*only one address per consent form is allowed*):

_____
Company Name or Person's Name Phone #

_____
Address State zip code Fax #

RELEASE the following information (*you must be specific in including dates and checking all information that you wish released in the boxes provided below):*
Treatment dates covering the period _____ to _____

- ❑ Discharge Summary
- ❑ History and Physical
- ❑ Operative Report
- ❑ Consult
- ❑ Radiology Report
- ❑ Lab report
- ❑ Pathology Report
- ❑ ER Report
- ❑ Provider's Notes
- ❑ Other: _____

The above information is released for the following purpose only (*check all that apply*):

☐ Medical Care ☐ Legal Matter ☐ Insurance ☐ Personal ☐ Other

RELEASE OF SENSITIVE AND/ OR PROTECTED INFORMATION: *Federal law protects certain types of medical information. The following types of information require your specific, informed consent prior to release. You must put a signature on the line next to each type of information listed below for which you authorize release to the party named above on this consent.*

I AM AWARE THAT MY RECORDS CONTAINS INFORMATION RELATED TO:

- Mental Health: _____
- Alcohol and / or Drug (I understand that all related information is protected under Federal Regulation 42CFR and have the right to refuse release.) _____
- HIV related information (I understand that all released information is protected under MA State Law and have the right to refuse release.) _____
- Other (please list): _____

I have carefully read this form and agree to release the information specified. I am not giving permission for redisclosure of this information. This release is valid up to 365 days from the date it is signed. This release is subject to revocation in writing, unless action made in good faith has already taken place.

Signature: _____ Date: _____

Witness: _____