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

| Name: Social Security #: Social Security #: Tel #: Medical Record is to be released to (only one address per consent form is allowed): Medical Record is to be released to (only one address per consent form is allowed): Ompany 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 we deteased in the boxes provided below): Treatment dates covering the period | hereby authorize | to | release the f | ollowing information from the medical record of |
|--|--|---------------|----------------|---|
| Medical Record is to be released to (only one address per consent form is allowed): Company Name or Person's Name | ame: | | | Date of Birth: |
| Medical Record is to be released to (only one address per consent form is allowed): Image: Company Name or Person's Name | | | | |
| Company Name or Person's Name State zip code Fax # RELEASE the following information (you must be specific in including dates and checking all information that you we leased in the boxes provided below): Treatment dates covering the period | - | | | Tel #: |
| RELEASE the following information (you must be specific in including dates and checking all information that you we leased in the boxes provided below): Treatment dates covering the period | Medical Record is to be released to | o (only one | e address j | per consent form is allowed): |
| RELEASE the following information (you must be specific in including dates and checking all information that you weleased in the boxes provided below): Treatment dates covering the period | ompany Name or Person's Name | | | Phone # |
| Discharge Summary | ddress | State | zip code | Fax # |
| Discharge Summary | ELEASE the following information (you mus | t be specific | in including | dates and checking all information that you wish |
| Discharge Summary History and Physical Pathology Report ER Report Consult 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 the party named above on this consent. IAM 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 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 subto revocation in writing, unless action made in good faith has already taken place. | eleased in the boxes provided below): | | _ | |
| □ History and Physical □ Pathology Report □ Consult □ Provider's Notes □ Provider's Notes □ Provider's Notes □ Other: □ 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 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 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 subto revocation in writing, unless action made in good faith has already taken place. | reatment dates covering the period | | to | |
| □ History and Physical □ Pathology Report □ Consult □ Provider's Notes □ Provider's Notes □ Provider's Notes □ Other: □ 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 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 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 subto revocation in writing, unless action made in good faith has already taken place. | □ Discharge Summary | | | Lab report |
| □ Operative Report □ Consult □ Provider's Notes □ Radiology Report □ Other: The above information is released for the following purpose only (check all that apply): Medical CareLegal MatterInsurancePersonalOther 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 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 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 subtor revocation in writing, unless action made in good faith has already taken place. | | | | |
| Radiology Report Description: 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 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 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 subtor revocation in writing, unless action made in good faith has already taken place. | | | | |
| The above information is released for the following purpose only (check all that apply): Medical CareLegal MatterInsurancePersonalOther 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 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 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 subtor revocation in writing, unless action made in good faith has already taken place. | | | | Provider's Notes |
| Medical CareLegal MatterInsurancePersonalOther 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 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 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 subtorevocation in writing, unless action made in good faith has already taken place. | Radiology Report | | | Other: |
| 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 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 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 subto revocation in writing, unless action made in good faith has already taken place. | Ç | | | |
| 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 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 subto revocation in writing, unless action made in good faith has already taken place. | medical information. The following types of You must put a signature on the line next to | of informatio | on require you | ur specific, informed consent prior to release. |
| 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 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 subto revocation in writing, unless action made in good faith has already taken place. | I AM AWARE THAT MY RECORDS O | CONTAINS | INFORMA | TION RELATED TO: |
| 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 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 subto revocation in writing, unless action made in good faith has already taken place. | Mental Health | | | |
| 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 subto revocation in writing, unless action made in good faith has already taken place. | Alcohol and / or Drug (I under | | | |
| 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 subto revocation in writing, unless action made in good faith has already taken place. | | | | |
| redisclosure of this information. This release is valid up to 365 days from the date it is signed. This release is subto revocation in writing, unless action made in good faith has already taken place. | • Other (please list): | | | |
| Signature: Date: | redisclosure of this information. This relea | se is valid u | p to 365 days | from the date it is signed. This release is subject |
| | Signature: | | | Date: |
| | | | | |