Medical Records Release Authorization

Patient Name:_____ SSN:_____

Date of Birth:_____ Home Phone:_____Cell:_____

Address:_____

City/State/Zip:_____Email:_____

A) I hereby authorize records **FROM**:

Name:_____

Address:_____

City/State/Zip:_____

Phone:_____

Fax:_____

B) To be released **TO**:

Arlington Family Practice

22 Mill Street, Suite 101

Arlington, MA 02476

Phone: 781-646-4345

Fax: 781-646-5091

C) For the purpose of:

_____**Check here if releasing copy of records to self**

_____Continuity of care/Transfer of care

_____Self/Personal Copy _____Litigation

_____Insurance _____Disability

_____Workers Comp _____Other

Date Range:_____to_____

_____Any & All

_____ Physician's Office note ____Immunizations

_____Cardiology/EKG Report

_____Operative/Procedure Reports

_____Radiology Reports _____Lab/Path Reports

_____ Other_____

I understand that authorizing the disclosure of the health information is voluntary. I can refuse to sign the authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of this information carries with it the potential for authorized red-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavior health services, and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do herby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

Signature of Patient/Parent/Guardian or Authorized Representative **Date**

This authorization will expire one year from the date above