Family Medicine Associates
Westfield, Massachusetts

# AUTHORIZATION FORM FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Family Medicine Associates to disclose the Protected Health Information described below to:

_____

_____

Are you leaving the practice? Yes ☐ No ☐

Reason you are leaving _____

Date records to be picked up _____

Protected Health Information to be released:

☐ Entire Record ☐ Health Summary ☐ Labs ☐ Radiology ☐ Other

**Dates to be included** from: _____ to _____

Massachusetts state law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions. Please indicate below the information you wish to be included in this release:

**I** ☐ **DO/** ☐ **DO NOT** authorize FMA to release information pertaining to testing, treatment, or diagnosis of psychiatric, drug, and/or alcohol abuse, sexually transmitted diseases, HIV/AIDS related testing, diagnosis and/or treatment. **Initials:_____**

1. I understand I may revoke this authorization in writing at any time. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other actions has been taken in reliance on an authorization I have signed.
2. I understand information used or disclosed pursuant to this authorization could be subject to re-disclosure by the patient and if so may not be subject to federal or state law protecting its confidentiality.
   - If not previously revoked, this authorization will expire on _____, or for a period not to exceed six (6) months.

SIGNED BY: _____ DATE: _____

Signature of Patient or Legal Guardian

_____ _____

Print Patient's Name | Patient's Date of Birth

_____ _____

Print Name of Legal Guardian, if applicable | Relationship to Patient