AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL RECORD INFORMATION
RETURN COMPLETED FORMS TO:
FAMILY MEDICINE ASSOCIATES
75 SPRINGFIELD ROAD, SUITE 1 WESTFIELD, MA 01085
OR FAX TO: 413-562-1716

Patient Information

Patient Name (Please Print): _____ Date of Birth: _____
Patient Address: _____ Phone #: _____
City: _____ State: _____ Zip: _____ Email: _____
Name of Insurance Plan: _____

I hereby Authorize Family Medicine Associates to:

Please choose one: O Release my medical record information to O Obtain medical information from

Name/Facility: _____ Attention: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Fax #: _____

Purpose of Request: O Personal O Referral O Legal O Insurance O Other _____
O Transfer from Practice/Reason?

Specific Records to be released:

O Please provide me with a 2 year abstract of my medical records.
O Please provide me with a copy of my entire medical record.
O Please provide the specific information as outlined below:

_____ Date(s) of Treatment _____
_____ Date(s) of Treatment _____

Copy Fee: Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. FMA will cap the fee at $25.00 (plus postage) for a two year abstract of your medical record. If you want the entire medical record or more than the two year abstract, the rate will increase proportionately based on the cost. At no time will the cost-based fees exceed Massachusetts law (MGL Chapter 111; Section 70).

Authorization to Release Protected Health Information:

Important - It is extremely important that you select either YES or NO and Initial each item contained in this section *Authorization to Release Protected Information.* Please do not skip any line item as it could impact our ability to fulfill your request and cause additional delays.

	Yes	or	No	Initial
>Mental/Behavioral Health records	☐		☐	_____
>HIV/AIDS, including HIV antibody and antigen testing, and HIV/AIDS diagnosis or treatment	☐		☐	_____
>Genetic testing	☐		☐	_____
>Sexually Transmitted Diseases	☐		☐	_____
>Abortion	☐		☐	_____

Term: This Authorization will remain in effect until Family Medicine Associates (FMA) fulfills this request.
Revocation: I understand that I may revoke this Authorization at any time by requesting it of FMA in writing at the address listed above. The revocation will be effective immediately upon FMA receipt of my written notice. I understand the revocation will not have any effect on any action taken by FMA in reliance on this Authorization before it received my written notice of revocation.
Effect on Treatment: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation, quality or payment for such treatment at FMA.
Potential Redisclosure: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state Privacy laws, and my Protected Health Information may no longer be protected by the applicable and federal law once it is disclosed by FMA.

Sign Here _____ Date _____
Signature of Patient Date

Signature of Personal Representative Authority to act for patient Date

Rev: 05/2018