

Family Medicine Associates
Authorization for the Release of Medical Records

RETURN COMPLETED FORMS TO: 75 SPRINGFIELD ROAD, SUITE 1 WESTFIELD, MA 01085

OR FAX TO: 877-347-6094

Where are the records being released from?

Facility Name:

Provider Name(s):

Address:

City:

State:

Telephone:

Fax:

Tell us about the patient.

Name:

DOB:

SSN: XXX-XX-

Email:

Address:

City:

State:

Zip:

Phone#:

Fax#:

Where are we sending the records?

Name:

Email:

Address:

City:

State:

Zip:

Phone#:

Fax#:

What would you like released? Check all that apply.

☐ All Records

☐ Office/Clinic Notes

☐ Operative Reports

☐ Psychological/Psychiatric, if any

☐ Lab/Pathology Results ☐ Radiology Reports ☐ Immunization Records ☐ Substance Abuse, if any

☐ Last Two Years of Records ☐ Dates _____ to _____

☐ Other _____

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

☐ Substance Abuse, if any ☐ AIDS/HIV/STDs, if any ☐ Psychological/Psychiatric conditions, if any

Purpose of Disclosure: Why are we sending the records?

☐ Personal Use ☐ Litigation/Legal ☐ Insurance ☐ Continuation of Care ☐ Transfer to New Physician

Delivery Method: How would you like the records sent?

☐ Email ☐ Fax ☐ Postage (additional fee applies)

Patient's Signature (or Legal Representative)

I hereby authorize Family Medicine Associates, LLC to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, *unless otherwise noted*. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient listed above and will no longer be protected by federal regulations. I understand I can refuse to sign this authorization and my healthcare provider may not condition treatment on my signing this authorization.

Patient's Signature: _____ **Date:** _____

Print Name: _____

When patient is not competent to give consent, the signature of a guardian or other legal representative is required.

Signature of Legal Representative: _____ **Date:** _____

Print Name: _____ **Relationship:** _____