Family Practice Group
11 Water St, Suite 1A
Arlington, MA 02476

Authorization For Use or Disclosure of Medical Record Information

Patient Information

Patient Full Name: _____ Date of Birth: _____

Any other Previous Names: _____

Patient Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Email: _____

Authorization to Release

I hereby authorize **Family Practice** to (please choose one) ☐ Release my medical information to: ☐ Obtain information from:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ○ Personal ○ Referral or 2nd Opinion ○ Legal ○ Insurance ○ Other _____

○ Transfer from Practice/Reason?_____

Information to be Released

○ Please provide a 2 year abstract of my records

○ Other - please be specific, include dates and MD's under comments-

Comments

Authorization to Release Protected Information

STOP

IMPORTANT- It is extremely important that you select "YES" or "NO" for each selection under the category of **Authorization to Release Protected Information**. Please do not skip any line items as it could impact our ability to fulfill your request and cause additional delays.

Yes ☐	☐ No	**Mental Health or Psychotherapy Notes/Information**
Yes ☐	☐ No	**HIV Tests & Related Information**
Yes ☐	☐ No	**Alcohol and/or Substance Abuse Treatment**
Yes ☐	☐ No	**Genetic Testing**
Yes ☐	☐ No	**Social Worker Communication**
Yes ☐	☐ No	**Sexual Abuse**
Yes ☐	☐ No	**Developmental Disability**
Yes ☐	☐ No	**Sexually Transmitted Disease (STD's)**
Yes ☐	☐ No	**Other**_____

Other sensitive information?

Sign Here Date Here

Know Your Privacy Rights Refer to the HIPAA "PRIVACY NOTICE"

_____

Patient's Signature **Date***

_____

Parent/Legally Recognized Representative Signature** **Date****

Rev. 12/18

*This Authorization is valid for 12 months unless you specify other wise (enter expiration date)_____. You may revoke this Authorization at any time by providing a written statement, except to the extent that the provider has already completed action on it.

*The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem.

** If you are the legally recognized represenatative of the patient you must provide supporting documentation.

The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. The provider will not condition treatment on payment of the provision of this Authorization.