AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete form thoroughly. Your medical records cannot be released until this form is completed, signed by the patient or legal guardian, and returned to this office.

Step 1 Completed	STEP 1: Information about you PLEASE PRINT!! Patient Name: ______________________________ Date of Birth: ____________________ Last First Address: ____ Street City State Zip
Step 2 Completed	STEP 2: Who has the records now? PLEASE PRINT!! I hereby authorize: Chelmsford Primary Care, LLC: 2 Meeting House Road, Chelmsford MA 01824 Record requests will default to the last five years. If something specific is being requested, please note: ____________________
Step 3 Completed	STEP 3: To whom do you wish to release your records? PLEASE PRINT!! No Charge Email Option, please print your email address very clearly. Records emailed will be sent via Secure Email only to the address listed on this form: Email Address: ______________________________________ Mail Option: Fee applies to records printed / mailed to yourself. No fee for mailed records to another provider's office: Address:____ ____ ____
Step 4 Completed	STEP 4: Your signature This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for redisclosure beyond recipient is required. ______________________ ______________________ Patient's Signature Parent/Guardian's Signature
Step 5 Completed	STEP 5: Release for Sensitive Information: I UNDERSTAND THAT IF MY MEDICAL RECORD CONTAINS INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, VENEREAL DISEASE, SOCIAL SERVICE, HEPATITIS B TESTING/TREATMENT, AND/OR SENSITIVE INFORMATION, I AGREE TO ITS RELEASE. ______________________ ______________ Signature of Patient or Legal Guardian Date
Step 6 Completed	STEP 6: Release of HIV Information: IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV (AIDS) TESTING/TREATMENT RECORDS RELEASED YOU MUST SIGN AND DATE ON THE LINE BELOW. I AGREE TO THE RELEASE OF THIS INFORMATION. ______________________ ______________ Signature of Patient or Legal Guardian Date
Optional	STEP 7: Reason for Leaving Chelmsford Primary Care Practice: ____ ____ ____