

Patient instructions: Fill out this form completely and send it to your previous healthcare provider. Please note: There may be fees for copies of medical records. It is a good idea to contact your previous healthcare provider for details on their process.

Patient Information

Patient's Name: _____

Patient's Address: _____ D.O.B: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Release Information

I give permission for the following person or place to send my medical records:

Name/Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

to:

Reliant Medical Group - Health Information Management
385 Grove Street, Worcester, MA 01605
Fax #: 508-407-7735

Purpose of Request:

Transfer of my care to new primary care provider.

Information to be Released (to help lower your costs, your new provider usually only needs the following)

- Last 3 years of visit notes and diagnostic test results
- Last 5 years of visit notes and diagnostic test results (*recommended for children under 5 years old*)
- Also include most recent colonoscopy/EKG if not in the date range above
- Other (*please explain*): _____

Special Authorization for Release of Statutorily Protected Information

The items below will NOT be shared unless you approve them. (Please check and initial.)

- | | | | |
|--------------------------------------------------------|----------------|---------------------------------------------------------------------------------|----------------|
| <input type="checkbox"/> Genetic Testing | Initial: _____ | <input type="checkbox"/> Psychiatric Health-including Behavioral Medicine Notes | Initial: _____ |
| <input type="checkbox"/> HIV/AIDS Results | Initial: _____ | <input type="checkbox"/> Alcohol/Drug Abuse Treatment | Initial: _____ |
| <input type="checkbox"/> Sexually Transmitted Diseases | Initial: _____ | (Including 42 CFR Part 2 Records) | |

I understand that I can cancel this permission at any time by writing to the Medical Records Department. This will not affect records already sent.

I understand this permission lasts for 12 months unless I cancel it sooner or write a different end date here: ____/____/____.

I understand that signing this form is my choice. I do not have to sign it in order to get care.

I understand my records may include information about mental health, substance use, or other private, sensitive topics.

I understand that once my information is shared, it carries the chance of unauthorized re-release and may no longer be protected by federal privacy laws.

Signatures

Patient/Legal Representative Signature: _____ Date: _____

Print Name of Legal Representative: _____ Relationship to Patient: _____

*A copy of legal document showing you can act for the patient must be included.