Please send completed form to:

Reliant Medical Group
385 Grove Street, Worcester, MA 01605
(508) 721-1142 • Fax: (508) 453-8030
email: release@reliantmedicalgroup.org

Southboro Medical Group
24 Newton Street, Southborough, MA 01772
(508) 460-3015 • Fax: (508) 460-3143
email: release@reliantmedicalgroup.org

Authorization to Disclose Medical Record Information

Completed by (For office use only): MRN: ____________________

Initials: ________ Dept: ____________________ Date: ______________

Patient Information

Patient's Name: ____

Patient's Address: ______________________________ D.O.B: ______________

City: ______________ State: ________ Zip: ________ Phone #: ( ) ______________

Release Information

I hereby authorize Reliant Medical Group to: ☐ **Mail my medical records to:** ☐ **Request my medical records from:**

Name/Facility: ______________________________ Attention: ______________

Address: ______________________________ Phone: ______________

City: ______________ State: ________ Zip: ________ Fax: ______________

Purpose of Request: ☐ Personal ☐ Continuing care (Referral/2nd Opinion) ☐ Legal ☐ Insurance

☐ Transfer of care (New Physician)* ☐ Other: ______________________________

*Reason for Transfer: ☐ Moving ☐ Insurance Change ☐ Dissatisfied ☐ Other: ______________________

Information to be Released

Please refer to the website for Frequently Asked Questions (FAQ) sheet for information regarding fees. Requests for Radiology Images/ Films or billing information must be made directly to each of those departments.

**Please specify date ranges.*

☐ Abstract (includes immunization, 2 years of office visits and labs, and 5 years of radiology and diagnostic reports and consults - HIPAA cost-based fee capped at $25.00 plus postage if applicable.)

☐ Office Visits *__________ to __________ Specify Provider(s): ______________________________

☐ Lab Results: *__________ to __________ ☐ Radiology Reports: *__________ to __________

☐ Other *(please be specific)*: ____

Statutorily Protected Information

The following items will not be included unless specifically authorized.

☐ Alcohol/Drug Abuse Treatment Inital: _______

☐ Genetic Testing Inital: _______

☐ HIV/AIDS Results Inital: _______

☐ Psychiatric Health-including Behavioral Medicine Notes Inital: _______

☐ Sexually Transmitted Diseases Inital: _______

- *I understand that I have a right to revoke this authorization at any time by providing a written statement to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand this authorization is valid for 90 days unless otherwise specified or revoked. Please specify an expiration date if less than 90 days: ____/____/______.*
- *I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment.*
- *I understand that my health record may contain general information related to my mental health, drug/alcohol abuse, or other information that I may consider sensitive. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and may not be protected by federal confidentiality rules.*

Signatures

Patient/Legal Representative Signature: ______________________________ Date: ______________

Print Name of Legal Representative: ______________________________ Relationship to Patient: ______________

*Copy of signed supporting legal document showing your status as authorized representative with access to member's/patient's records must accompany request.

This authorization must be completed in its entirety or it will not be processed.

FORM # 11989 (1/18) INV