

Authorization to Disclose Medical Record Information

Please send completed form to:
35 Millbury Street, Auburn, MA 01501
(508) 721-1142 • Fax: (508) 832-2789

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:** **Obtain 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 - capped at \$25 fee plus postage.)
 Office Visits * _____ to _____ Specify Provider(s): _____
(If not specified, all visits with all Reliant Medical Group providers during this period will be released.)
 Lab Results: * _____ to _____ Radiology Reports: * _____ to _____
 Other (please be specific): _____

Statutorily Protected Information

The following items will not be included unless specifically authorized.

<input type="checkbox"/> Abortion	Inital: _____	<input type="checkbox"/> HIV/AIDS Results	Inital: _____
<input type="checkbox"/> Alcohol/Drug Abuse Treatment	Inital: _____	<input type="checkbox"/> Psychiatric Health-including Behavioral Medicine Notes	Inital: _____
<input type="checkbox"/> Genetic Testing	Inital: _____	<input type="checkbox"/> 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 redislosure 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.