

Authorization for Release of Medical Records

FULLY complete steps 1-5 or the release will be VOID. Medical records cannot be released until the form is completed, signed by patient or legal guardian. Allow **20 work days** minimum to prepare records. *Fee: As of 6/18/2008, see pre-payment fees listed on bottom of this form.

<-- AS YOU COMPLETE EACH STEP, BELOW, PLEASE MAKE A CHECKMARK IN THE BOX PROVIDED TO THE LEFT

Step 1 Completed <input type="checkbox"/>	STEP 1 <u>Information about patient:</u> PLEASE PRINT!! PATIENT NAME: _____ DATE OF BIRTH ___/___/___ <div style="display: flex; justify-content: space-around; width: 100%;"> Last First </div> ADDRESS: _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Street City State Zip </div>
Step 2 Completed <input type="checkbox"/>	STEP 2 <u>Who has the records now?</u> PLEASE PRINT!! I hereby authorize: _____ MD DMD Hospital Above's Address or FAX: _____ _____
Step 3 Completed <input type="checkbox"/>	STEP 3 <u>Which records, and to whom do you wish to release your records to?</u> PLEASE PRINT!! <input type="checkbox"/> All Records <input type="checkbox"/> Specific: _____ <div style="margin-left: 100px;">Name Records</div> <input type="checkbox"/> Date of Treatment: _____ to _____ OTHER: _____ To: _____ MD DMD Self (check one) Address: _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Street City State Zip </div> Or be FAXED (must be under 35 pages and FAXED to a secure location) to: _____ - _____ - _____
Step 4 Completed <input type="checkbox"/>	STEP 4 <u>2 Signatures and Date:</u> Authorization valid for 90 days to the named recipient and may be revoked at any time in writing prior to expiration date/record release being completed. A fee in advance of release may be required. X _____ X _____ Date _____ Required Patient or Parent/Guardian Signature Required Witness Signature Required
Step 5 Completed <input type="checkbox"/>	STEP 5 <u>Release for sensitive Information:</u> I, THE UNDERSIGNED, UNDERSTAND THAT MY MEDICAL RECORD MAY CONTAIN INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, VENEREAL DISEASE, SOCIAL SERVICE, HEPATITIS B TESTING/TREATMENT, AND/OR SENSITIVE INFORMATION AND AGREE TO ITS RELEASE. X _____ Date _____ Required Patient or Parent/Guardian Signature Required
Optional <input type="checkbox"/>	OPTIONAL <u>Release for HIV Information:</u> IN ADDITION TO THE ABOVE SIGNATURES, <i>IF</i> YOU AGREE TO THE RELEASE OF YOUR HIV (AIDS) TESTING/TREATMENT RECORDS YOU MUST SIGN AND DATE ON THE LINE, BELOW: X _____ Date _____ Required Patient or Parent/Guardian Signature Required

Holistic Family Practice, Inc., 65 Newburyport Turnpike, Newbury, MA 01951 978.465.9770 FAX 978.465.9004

***Pre-Payment Fees: \$.50 per page + \$15 per request. Excess of 100 pages are billed at a rate of \$.25 per page.**