Authorization for Release of Medical Records

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

Please print carefully. Forms not **FULLY** completed will **not** be processed. Fully completed forms that are not accompanied by the required $20 pre-payment fee check will **not** be processed.

Patient First and Last Name

Patient Email Address - **Required for Digital Downloads**

Current Mailing Address

Patient's Date of Birth via MM/DD/YYYY

City, State Zip Code

Patient's Telephone Number

Holistic Family Practice, Inc. is authorized to release this patient's protected health information to:

_____
Facility, or Practice Name (or Person's Name if not to a new PCP)

_____
Street or PO Box City State Zip

_____
Telephone Fax

1.The specific information to be disclosed: (**also** note digital download or CD if requesting records **to yourself**):

_____

SENSITIVE INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH should or should not be DISCLOSED: (one **required** **signature**, below, either on the YES **or** NO **signature line**)

YES, DISCLOSE THIS INFORMATION x_____

or

NO, **DO NOT** DISCLOSE THIS INFORMATION x_____

2. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or the facility receiving it, and would then no longer be protected by federal privacy regulations.
3. I may revoke this authorization by notifying Holistic Family Practice, Inc. in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
4. I understand that I am not required to sign this authorization in order to receive treatment or to enroll in or be eligible for medical benefits.
5. **The purpose of this request:**_____

Above reason is **REQUIRED** (Transfer of of Care, Legal, Personal Copy, etc.)

This authorization **expires** on _____, 20_____, **OR** 60 days from the date signed.

FEES FOR COPIES: As of October 1st 2017, a pre-payment requirement of $20 **must accompany this form.** Make your check out to Holistic Family Practice, Inc. and mail to HFP, 65 Newburyport Turnpike, Newbury, MA 01951

THIS FORM MUST BE FULLY COMPLETED and SHOW YOUR SIGNATURE BOTH IN STEP 1 and BELOW

X_____ _____ _____

Signature of named Patient or, if under 18, the *Signature of Guardian, or *Signature of Legal Representative of Patient's Estate

Date of Signature

***If not the patient's signature, a description of the signer's Authority to Act**