AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

South Shore Internal Medicine Assoc., Inc.
100 Highland Street, Suite 300 Milton, MA 02186
Phone: 617-698-8855
Fax: 617-224-1007

Your medical records cannot be released until this form is completed, signed by the patient or legal guardian and returned to our office. There may be a processing fee associated with this request.

STEP 1: Information about you:

PATIENT NAME: _____ DATE OF BIRTH: _____
Last First

ADDRESS _____
Street City State Zip Code

STEP 2: Reason for requesting your medical records (please check any that apply):

☐ TRANSFER OF CARE TO ANOTHER PHYSICIAN OR HOSPITAL
☐ COORDINATION OF CARE
☐ OTHER (Please explain)

STEP 3: Who has the records now?

I hereby authorize: _____ MD/DO (circle one)
Physician's Address: _____
_____

STEP 4: To whom do you wish to release your records?

To release the following information: Please specify:

☐ ALL RECORDS (Complete copy of records may take up to 3 weeks to process)
OR
☐ DATES OF TREATMENT: _____ to _____ Other: _____

Release to: _____
Address: _____
Fax number: _____
Phone Number: _____

STEP 5: Your signature

This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for redisclosure beyond recipient is required.

_____
Patient's Signature Date

_____ _____
Witness Signature Date Parent/Guardian's Signature Date

STEP 6: Release for Sensitive Information

I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric, venereal disease, social services, hepatitis B testing/treatment, and/or sensitive information, I agree to its release.

_____ _____
Signature of Patient or Legal Guardian Date

STEP 7: Release of HIV Information

In addition to the above signatures, if you want your HIV (AIDS) testing/treatment records released you **must** sign and date on the line below. I agree to the release of this information.

_____ _____
Signature of Patient or Legal Guardian Date