Authorization for Release of Medical Information

Davis Square Family Practice
Attention: Medical Records
260 Elm Street, Suite 105 Somerville, Massachusetts 02144
contact@dsfamilypractice.com
617-666-9577 (Tel) 617-666-3190 (Fax)

Date of Birth_____ Social Security Number_____

Patient Name_____ Telephone #_____
Last First Middle Initial

Home Address_____
Street/Apt # City/State Zip Code

I authorize (name of Hospital, Facility, or Person)_____to:
☐ Obtain from ☐ Disclose to ☐ Communicate with

Name of Hospital or Facility or Person:_____

Street/Suite Number_____

City/State/ Zip Code_____

Phone Number_____Fax Number_____

Disclose the following information for the treatment dates:_____to _____
☐ Entire Medical Record or
☐ Face Sheet ☐ Admission Note ☐ History & Physical ☐ Progress Notes
☐ Consults ☐ Lab Reports ☐ Pathology Reports ☐ X-ray/Scan/Imaging Reports
☐ Operative Notes ☐ Emergency Reports ☐ Physical Therapy Notes ☐ Clinic Notes
☐ Medication Notes ☐ Treatment Plan ☐ Discharge Summary
☐ Abstract (Discharge Summary, History & Physical, Operative, Pathology, and Test Results)
☐ Other (Specify)_____

Purpose for Record Release: ☐Moved ☐Insurance ☐Legal Matter ☐Personal Use ☐Referral to Specialist

Other (Please Specify):_____

TERM: This Authorization expires/terminates/ends:
☐ 90 days from the date signed ☐ On Other date, reason or event_____
By my signature below, I hereby authorize Davis Square Family Practice to obtain, use and/or disclose my health information for the term of this Authorization for the specific purpose(s) listed: ("At the request of the patient" is sufficient if the patient is initiating this Authorization).

I understand that once Davis Square Family Practice discloses my health information to the recipient, Davis Square Family Practice cannot guarantee that the recipient will not disclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of Davis Square Family Practice's treatment of me; except, however, if my treatment at Davis Square Family Practice is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Davis Square Family Practice may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Davis Square Family Practice. The revocation will be effective immediately upon Davis Square Family Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by Davis Square Family Practice in reliance on this Authorization before it received my written notice of revocation.

(OVER)

I have read and understand the terms of this Authorization, and I have had an opportunity to ask questions about obtaining, using, and disclosing my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Davis Square Family Practice to obtain, use and/or disclose my health information in the manner described above.

_____ _____

Signature of Patient Date

If the patient is an unemancipated minor or is otherwise incapacitated (physically or mentally), obtain the following signatures:

_____ _____ _____

Signature of Personal Representative | Description of Authority | Date

MY HIGHLY CONFIDENTIAL INFORMATION

By signing my name next to a category of highly confidential information listed below, I specifically authorize obtaining, using and/or disclosing the type of highly confidential information indicated next to my signature, if any such information will be obtained, used or disclosed pursuant to this Authorization.

- Information about a Mental Illness, Behavioral Health or Developmental Disability _____
- Information related to confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor or other allied mental health professional or human services professional_____
- Information about HIV/AIDS Testing, Status or Treatment _____ (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- Information about Venereal Disease(s) Status or Treatment _____
- Information about Substance (i.e., alcohol or drug) Abuse Status or Treatment_____
- Information about Abuse of an Adult with a Disability _____
- Information about Sexual Assault _____
- Information about Child Abuse and Neglect _____
- Information about Genetic Testing _____
- Information about abortion _____
- Information about mammography_____
- Information about family planning services_____
- Information related to mental health community program records_____
- Information about research involving controlled substances_____
- Information about domestic violence_____
- If I am an emancipated minor, information about treatment/diagnosis (except to my parents) _____

DATE:_____