AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM

I, _____hereby voluntarily authorize the disclosure of information from my health record. (Name of Patient)

Patient Information:

Patient Name: _____Record Number: _____

Address: _____ Date of Birth: _____

Information Requested:

_____

_____

_____

Purpose of Release:

_____

_____

_____

The Information Is To Be Provided To:

Name of Person/Organization/Facility: _____

Address: 1256 Park Street, Suite 101, Stoughton, MA 02072

Phone: (781) 573-3977 Fax: (781) 573-3955

_____ _____

Patient's Signature or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship of Patient

This information is to be released for the purpose stated above and may not be used by recipient for any other purpose.

PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS