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# Authorization for Release of Medical Information

**ALL SECTIONS BELOW MUST BE COMPLETED FOR PROCESSING**

**Patient Name:**________________________________________ **Relationship to Patient :** ______________
Last First MI

**Maiden or Former Name :** ________________ **Date of Birth:** ____ / ____ / ______

**Patient Address:**__________________________________________________ **Phone:** ( ) ____ - ______
Street Apt. # City State Zip

☐ **OBTAIN MEDICAL RECORDS -** I hereby authorize the below named Physician/Facility to release my health information to:

**Atkinson Family Practice, 17 Research Drive, Amherst, MA 01002**

**Previous Physician/Practice:**______________________________ **Phone:** ( ) ____-______ **Fax:** ( ) ____-______

**Address :**__________________________________________________
Street Suite. # City State Zip

☐ **DISCLOSE MEDICAL RECORDS -** I hereby authorize **Atkinson Family Practice** to release my health information to:

**New Physician/Practice :**______________________________ **Phone:** ( ) ____-______ **Fax :**( ) ____-______

**Address :**__________________________________________________
Street Suite. # City State Zip

## Purpose of this Release:

[ ] Transfer** [ ] Continuity of Care (not leaving practice) [ ] Legal [ ] Insurance [ ] Consult Appointment [ ] Personal

[ ] Other: ____________________ ** IF YOU ARE TRANSFERRING OUT OF AFP, PLEASE TELL US WHY ON THE BACK OF THIS FORM? THANK YOU!

## Medical Information to be Disclosed:

[ ] All Records [ ] Consultations [ ] Diagnostic Tests (labs, x-rays, EKG, colonoscopy, etc.) [ ] Hospital Notes

[ ] Progress Notes [ ] Immunizations [ ] Other: ______________________________

## Authorization Covers:

[ ] Past Three Years [ ] Entire Period of Care, which began in : ____ ______ [ ] Specific Dates: ______________
Mo Yr

**Release of sensitive, protected information related to testing, diagnosis and/or treatment for HIV/AIDS, sexually transmitted diseases, drug/alcohol use/treatment and/or mental health/psychiatry is authorized only through express consent.**

**INDICATE THE AREAS YOU AUTHORIZE BY INITIALING EACH ONE BELOW. AUTHORIZATION IS NOT VALID UNLESS INITIALED:**

____ **HIV/AIDS** ____ **Sexually Transmitted Disease** ____ **Mental Health/Psychiatry** ____ **Drug/Alcohol**

This authorization **EXPIRES ON**: ______ ______, or if unspecified, one year from date of signature.
Mo Yr

I understand that I may revoke this authorization at any time by making a written request to Atkinson Family Practice. I understand that actions taken in reliance on this authorization prior to revocations may not be reversible. I understand that Atkinson Family practice may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization. State law prohibits redisclosure without written authorization.

**I acknowledge that I have signed this Authorization voluntarily:**

______________________________ ______________________________ __________
Signature of Patient or Authorized Representative Print Name of Patient or Authorized Representative Date

**FOR OFFICE USE ONLY ----**

**RELEASE FAXED ON:** ____________________ **RECORDS SENT BY** ____ **FAX:** ____ **MAIL:** ____ **PICKED UP: ON** ______________

**If you are transferring out of AFP, would you kindly tell us why? Your feedback is so important to us for ensuring our patients receive only the finest in care – please be specific.**

**Thank you!**