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Atkinson Family Practice



Caring for you and your Whole Family

17 Research Drive
 Amherst, MA 01002
 Phone (413) 549-8400
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www.doctorkate.net

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 _____

