Grove Medical Associates, PC

Primary Care Center of Excellence

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

Please print all information
Name of Patient: _____ DOB: _____
Patient's Street Address: _____
_____
Telephone: _____
Reason for request: ☐ getting second opinion only ☐ living elsewhere during part of year ☐ leaving group due to move ☐ leaving group due to dissatisfaction ☐ changing PCP ☐ records for specialist appointment ☐ other: _____
As the patient or the patient's legal representative, I authorize:
Name of physician: _____
Address of physician: _____
To disclose to:
Name of recipient: _____
Address of recipient: _____
If these records are to be picked up at our offices, I authorize them to be released to:
Name of recipient: _____
Address of recipient: _____
Relationship to patient: _____
MEDICAL RECORDS
(Please select one)
I specifically_____ to the disclosure and release of sensitive medical information
(consent or refuse)
concerning my treatment of mental illness, Human Immunodeficiency Virus, drug addiction, abuse, or dependency, or venereal disease, if any.
☐ Only those specific records as I describe: _____
_____
I may withdraw my consent by giving written consent to the above party, at any time prior to the disclosure or release of the information. In the absence of the withdrawal of permission, this consent will expire one year after it is signed. A photographic copy of this authorization shall be as valid as the original. I may refuse to sign this authorization. If so the refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. If my information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the recipient and, as a result, it may no longer be protected by the Privacy Rule.
Massachusetts law requires medical records to be copied within thirty days from receipt of the request and allows for a reasonable processing fee. I agree to pay this fee.

_____
Authorized Signature Date

_____ _____
Print Name Relationship if not patient or custodial parent
(Must prove guardianship or other legal authorization)

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www.grovedoc.com