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 _____ Following a provider leaving Grove Medical_____
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 records are to be picked up at our office, they will be released ONLY to the patient directly.

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. For producing copies of records, Massachusetts law allows physicians to charge a reasonable, cost-based fee based on supplies, labor, and including postage if records are mailed. I understand and agree to pay for costs associated with this service.

_____ _____
Authorized Signature Date

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