

## 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: \_\_\_\_\_  
\_\_\_\_\_

Phone of recipient: \_\_\_\_\_ Fax of recipient: \_\_\_\_\_

**If records are to be picked up at our office, they will be released ONLY to the patient directly. If you have any questions regarding this policy please call the Medical Records Department at 508-753-2060, option 7**

### 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 \_\_\_\_\_ (Must prove guardianship or other legal authorization)

Relationship if not patient or custodial parent