



Authorization for Release of Medical Information

Please complete this form thoroughly. Your medical records cannot be released until this form is completed, signed by the patient or legal guardian and returned to this office.

<p>Step 1 Please fill in demographic information.</p>	<p><u>Information about you:</u></p> <p>Patient Name: _____ Date of Birth: _____</p> <p>Address: _____</p>
<p>Step 2 This section has been completed for you.</p>	<p><u>Who has the records now?</u></p> <p>I hereby authorize: Village Primary Care 10 Research Place, Suite 200 North Chelmsford, MA 01863 Phone: 978-323-7085 / Fax:978-323-7089</p>
<p>Step 3 Name and address to send your records to.</p>	<p><u>To whom do you wish to release your records to?</u></p> <p>Please send my records to (check one): Myself / New PCP (If New PCP, fill out information below)</p> <p>Name: _____</p> <p>Address: _____</p>
<p>Step 4 Please read and authorize what information is to be sent.</p>	<p>If my initials appear here _____, I authorize the release of ALL RECORDS which include office notes, lab reports, diagnostic imaging, and problem list.</p> <p style="text-align: center;">OR</p> <p>Release only the following: _____</p>
<p>Step 5 Please read thoroughly, sign and date.</p>	<p>I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric, venereal disease, social service, Hepatitis B testing/treatment, HIV/AIDS testing and/or treatment, and/or any other sensitive information, I am agreeing to the release of this information.</p> <p>_____</p> <p style="display: flex; justify-content: space-between;">Patient Signature/Legal GuardianDate</p>
<p>Step 6 Please read thoroughly, sign and date.</p>	<p>I have carefully read and understand the above information, and so herein expressly and voluntarily consent to the disclosure of the above information about, or medical records of my condition to those persons or agencies named above. I hereby release the above named physician and covering physicians from all liability that may arise from the release of my medical records. This authorization will expire 12 months from the date shown below.</p> <p>_____</p> <p style="display: flex; justify-content: space-between;">Patient Signature/Legal GuardianDate</p>