**Arlington Family Practice, P.C**

**22 Mill St. Suite 101 Arlington, MA 02476**

**Ph: 781-646-4345 Fax: 781-646-5091**

# Authorization to Disclose Medical Record Information

Name: _____ DOB: _____ Phone #: _____

Address: _____ City/State/Zip: _____

**I hereby authorize Arlington Family Practice, P.C to [ ] Obtain my records from [ ] Release my medical records to**

Name/Facility: _____ Attention: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

Purpose of Request: [ ] Personal [ ] Legal [ ] Continuity of Care [ ] Transfer of care [ ] Other

Information to be released: [ ] All records [ ] Labs [ ] Immunizations [ ] Office visits/physicals

[ ] Imaging [ ] Specialist reports [ ] Other: _____

Dates of treatment: _____ to _____

**Your informed consent is required to release records containing the information below:**

| | | | |
|---|---|---|---|
| [ ] Mental Health | Initials: _____ | [ ] Depression/Anxiety | Initials: _____ |
| [ ] Alcohol/Substance Abuse | Initials: _____ | [ ] Domestic/Sexual Assault | Initials: _____ |
| [ ] HIV | Initials: _____ | [ ] Genetic Testing | Initials: _____ |
| [ ] STD's | Initials: _____ | [ ] Abortion | Initials: _____ |

I understand I have the right to revoke this authorization at any time by providing a written statement to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand, unless otherwise revoked or specified, this authorization is valid for 12 months (Please specify expiration date if other than 12 months: _____). I understand the revocation will not apply to my insurance company when law provides my insurer with the right to consent a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary, and that I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____