Acton Medical
ASSOCIATES
Adult & Pediatric Primary Care

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Full Name _____ DOB:_____

Patient Address: _____

_____

I hereby authorize Dr. _____of Acton Medical Associates, PC to □**release** □**obtain** my personal health information to/from:

Name: _____

Full Address: _____

_____

Reason for Release: _____ Insurance Change _____ Moving/Moved _____ More Convenient Location

_____ Personal Use _____ Appt. w/Specialist _____ New Primary Care Physician

_____ Other (please specify) _____

Information to Release:

_____ Entire Electronic Medical Record **(CD)** **(For transfer to another physician or personal use)** **$15.00**

_____ Entire Medical Record **(paper copy)** **(For personal use)** **$25.00**

_____ Other (Please be specific)_____

Do you intend to continue receiving primary care from Acton Medical Associates? _____Yes _____No

Release of Information Requiring Specific Consent: The following categories of information may be included in your medical record. **INITIAL** below if you **DO NOT** want to have this information released:

_____Abortion _____ Behavioral/Mental Health _____HIV/AIDS

_____Alcohol/Drug Abuse _____ Genetic Testing _____Domestic Assault _____STDs

I understand that:

- I may inspect or obtain a copy of the protected health information described by this authorization.
- Acton Medical Associates, PC will not cause any adverse changes in payment or enrollment in my health plan (if applicable) or refuse to treat me solely because I have refused to sign this Authorization for Use or Disclosure of Protected Health Information.
- I may revoke this authorization in writing at any time by delivering such written notification to the Privacy Officer of Acton Medical Associates, PC. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
- Information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to Federal or State law protecting its confidentiality.
- This authorization will automatically expire 90 days from the date set forth below unless otherwise specified: _____(Date of expiration)

I have read and understand the above statements and authorize disclosure of the information requested above:

Signature of Patient (if 18 or over)/ Parent/ Legal Representative Date

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