



One Lyons St., Dedham, MA 02026
Tel: 781-329-1400 x1235 Fax: 781-329-4170

Upcoming Appt. Date \_\_\_/\_\_\_/\_\_\_
MRN \_\_\_\_\_
(office use)

Authorization to Release Medical Records

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
(Please Print)
Address: \_\_\_\_\_ Telephone No. \_\_\_\_\_
Street City State Zip

I hereby authorize Dedham Medical Associates (DMA) to release protected health information, including copies of the medical record of the above-named patient, to the following person or facility:

Name of Person or Facility \_\_\_\_\_ Telephone No. \_\_\_\_\_
Street City State Zip

Purpose of Release: [ ] Medical Care [ ] Legal [ ] Insurance [ ] Personal [ ] Leaving DMA\* [ ] Other: \_\_\_\_\_

\*If leaving Dedham Medical Associates, please check reason(s):

- [ ] Insurance change [ ] Moved/planning to move [ ] Location/wanted some place closer [ ] Couldn't get an appointment [ ] My provider left
[ ] Couldn't get a referral to a specialist I wanted [ ] Dissatisfied with care/service received (please explain on reverse)

Information to be released: Processing fees may apply.

Requests for Dental, Radiology Images/Films and Billing information must be made directly to each of those Departments.

- [ ] Office visits \_\_\_\_\_ to \_\_\_\_\_ Specific clinician(s): \_\_\_\_\_
(Please specify a date range) (Otherwise, all visits with all DMA clinicians during the period will be released)
[ ] Lab Results \_\_\_\_\_ to \_\_\_\_\_ [ ] Radiology Reports \_\_\_\_\_ to \_\_\_\_\_
(Please specify a date range) (Please specify a date range)
[ ] Abstract (Includes immunizations; 2 years of office visits / labs; 5 years of radiology and diagnostic reports) [ ] Immunizations only
[ ] Other (please be specific):

Release of Information Requiring Specific Consent: The following categories of information may be included in your medical record and WILL NOT be released unless you indicate your specific authorization by initialing each appropriate category.

- \_\_\_\_\_ Abortion \_\_\_\_\_ Behavioral/Mental Health \_\_\_\_\_ HIV/AIDS Results/Treatment
\_\_\_\_\_ Alcohol/Drug Abuse \_\_\_\_\_ Domestic Violence \_\_\_\_\_ Rape/Sexual Assault
\_\_\_\_\_ Genetic Testing \_\_\_\_\_ Sexually Transmitted Diseases



Please confirm that you have initialed all categories of information that you would like released.

I understand that:

- I may refuse to sign this authorization. I understand that my refusal will not affect my ability to obtain treatment at DMA unless (a) the only purpose of the treatment is to create health information for the disclosure listed above; or (b) if my treatment is related to participation in a research study for which this authorization is required.
I may revoke this authorization at any time by submitting a written notice of revocation to DMA at the address listed above. The revocation will be effective upon DMA's receipt of my written notice, except that it will not have any effect on any action already taken by DMA in reliance on this authorization.
Once DMA has disclosed my health information to the recipient, DMA cannot guarantee that the recipient will not disclose my health information to a third party.
This authorization will automatically expire 90 days from the date set forth below unless otherwise specified: \_\_\_\_\_
(Date of expiration)

Signature of Patient or Authorized Representative

Date

Printed Name of Patient or Authorized Representative

Relationship to Patient

THIS AUTHORIZATION MUST BE COMPLETED IN ITS ENTIRETY OR IT WILL NOT BE PROCESSED!