Westford Internal Medicine, P.C.
Please send completed form to:
133 Littleton Road, Suite 202 Westford, MA 01886
Phone: (978) 577-1946 Fax: (978) 692-4716

PATIENT REPRESENTATIVE RELEASE AUTHORIZATION

By completing this form I authorize Westford Internal Medicine to discuss/release my protected health information to one or more representatives identified. I may add or delete up to three individuals at any time by completing this authorization. By signing this form I give permission to Westford Internal Medicine to discuss/release protected health information with the below named party(s).

1. Patient Information

Name: _____

Date of Birth: _____ Home Telephone #: _____

Street: _____

City: _____ State: _____ Zip: _____

Day/Work Telephone #: _____

2. Patient Representative(s): Please identify up to three individuals to be your Patient Representative. Please ensure that the designated individual(s) below will need to provide the following information on you prior to Westford Internal Medicine discussing/releasing personal health information on your behalf:

- Patient Name
- Patient Date of Birth
- Patient Address

In addition they will also be asked to provide their name and date of birth for identification purposes only.

Please check one of the following boxes: ☐ Add ☐ Delete

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Patient Representative Telephone #: _____

Information to be released: ☐ All medical information ☐ Other: _____

_____
(PLEASE BE SPECIFIC)

TURN OVER AND COMPLETE SECOND PAGE

Please check one of the following boxes: ☐ Add ☐ Delete

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Patient Representative Telephone #: _____

Information to be released: ☐ All medical information ☐ Other: _____

_____
(PLEASE BE SPECIFIC)

Please check one of the following boxes: ☐ Add ☐ Delete

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Patient Representative Telephone #: _____

Information to be released: ☐ All medical information ☐ Other: _____

_____
(PLEASE BE SPECIFIC)

3. Authorization

I authorize Westford Internal Medicine to discuss my medical care with the individual(s) identified above. I understand there is no expiration date, and I may add or delete up to three individuals at any time by completing a new authorization. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Westford Internal Medicine. I understand the revocation will not apply to information that has already been provided in response to this release.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____
(NOT VALID UNLESS WITNESSED)

I understand that if my medical record contains information relating to drug and/or alcohol abuse, psychiatric, venereal disease, social service, hepatitis B testing/treatment, and/or sensitive information will be released by signing:

Patient Signature: _____ Date: _____

In addition to the above signatures, I would like information relating to HIV/AIDS testing/treatment released to the above party(s).

Patient Signature: _____ Date: _____