AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

Please Print:

PATIENT INFORMATION

Name: _____ Date of Birth: _____ SS#: _____
Address: _____
Home Phone: _____ Work: _____ Mobile: _____

RELEASE INFORMATION

I hereby authorize Westford Internal Medicine to:

☐ **Release my medical records to:** ☐ **Obtain my medical records from:**

Name/Facility: _____Phone:_____
Address: _____Fax:_____
City: _____State: _____ Zip code: _____
Purpose of request: ☐Personal ☐Continuing care (referral/2nd opinion)
☐Transfer of care (new primary care physician) If transferring please explain: _____
☐Legal ☐Insurance
☐Other_____

INFORMATION TO BE RELEASED ***(Please contact office for information regarding fees for copying records)***

☐ Entire record ☐ Other: _____

☐ Abstract (includes chart summary, immunization report, last 2 years of office visits & labs, and 5 years of diagnostic reports and consults)

*This authorization is valid until _____or if not specified for 180 days and maybe revoked at any time in writing prior to the expiration date. An additional authorization for re-disclosure beyond recipient is required.

Patient's 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's Signature: _____ Date: _____

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

Patient's Signature: _____ Date: _____

********ALL AREAS OF FORM MUST BE COMPLETE FOR FORM TO BE VALID********
INCOMPLETE FORMS WILL NOT BE PROCESSED

(2/2012)