FMA FAMILY MEDICINE ASSOCIATES

Medical Records Release Form

This request is directed to the following physician:

❑ **Dr. Steven Barrett** ❑ **Dr. Gregory Bazylewicz** ❑ **Dr. Harlow LaBarge**
195 School Street • Manchester, MA 01944 • Phones 978-526-4311, 978-526-7507 • Fax 978-525-2342

❑ **Dr. William Medwid** ❑ **Dr. Hugh Taylor** ❑ **Dr. Andrew Ting**
15 Railroad Avenue • Hamilton, MA 01982 • Phone 978-468-7381 • Fax 978-468-6020

❑ **Dr. Mark Allara** ❑ **Dr. Phillip Burrer** ❑ **Dr. Michael Yoon** ❑ **Dr. Meghan Tramontozzi**
147 South Main Street • Middleton, MA 01949 • Phone 978-774-2555 • Fax 978-774-8715

Patient Information:

Last name: _____ First name: _____ Middle initial: _____

Street or PO Box _____

City: _____ State: _____ Zip: _____

Telephone: _____ Date of birth: _____ S.S. # _____

I authorize the physician indicated above to release my medical records, including the diagnosis and records of any treatment or examination rendered to me, to:

Name: _____

Street or PO Box _____

City: _____ State: _____ Zip: _____

Purpose for disclosure:

❑ Changing physicians ❑ Consultation/second opinion ❑ Continuing care ❑ Legal ❑ School ❑ Insurance

❑ Workers Compensation ❑ Other: _____

The following categories of information will not be released from your record unless you indicate your authorization by checking the appropriate box and signing below:

Abortion	❑ Release	❑ Do not release
AIDS/ARC	❑ Release	❑ Do not release
Alcohol abuse	❑ Release	❑ Do not release
Substance abuse	❑ Release	❑ Do not release
Infertility studies	❑ Release	❑ Do not release
Mental health visits	❑ Release	❑ Do not release
Sexual abuse/rape	❑ Release	❑ Do not release
Venereal Disease	❑ Release	❑ Do not release

Other (specify) _____ ❑ Release ❑ Do not release

Patient signature: _____ Date: _____

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Signature Page

1. I understand that I may revoke this authorization at any time by notifying Family Medicine Associates in writing, and my revocation will be effective on the date of my notification.

2. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

3. I understand that, by authorizing this release of information, my health care and payment for my health care will not be affected.

4. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.

5. I have been informed that Family Medicine Associates ❑ will / ❑ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

6. I understand that, in compliance with Massachusetts statute, I will pay a fee of $ _____. There is no charge for medical records if copies are sent to facilities for ongoing care or follow-up treatment.

_____ Date _____

Signature of Patient

_____ Date _____

Signature of Parent / Legal Guardian / Authorized Person

_____ _____ Date _____

Records Received by Relationship to Patient

Date request filled:_____ By: _____

Identification presented:_____ Fee collected: $ _____

For FMA office use only