INSPIRE
FAMILY MEDICINE
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Medical Records Release Form

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Is hereby authorized to receive or disclose the following protected health information from the medical or psychiatric records of the patient listed below.

Patient First Name _____ Patient Last Name _____ Date of Birth:_____

Telephone _____ email _____

Address: _____

Release Records From:

Name of Doctor/Facility _____ Street Address _____

City, State, Zip code _____ Phone Number _____

Fax Number _____

Purpose of the Request:

☐ Medical Care ☐ Legal Care ☐ Insurance ☐ Personal ☐ Other

Information to be Disclosed:

New patients: please send "any and all records"

☐ Any and All Records ☐ Consult Notes ☐ Lab Results ☐ Vaccination Records ☐ Hospital Records
☐ Radiology Reports

Form Disclosure:

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to verbally, in paper format, or electronically.

Specifically Authorized Release of Information (initial IF applicable):

I understand that my health information may contain the following types of sensitive information and I expressly and voluntarily give permission to release the following:

_____To the extent that my medical record contains information concerning HIV antibody and antigen testing that is protected by MGL c 111 70F, an HIV/AIDS diagnosis or treatment. I specifically authorize disclosure of this information.

_____To the extent that my medical record contains information concerning alcohol or drug treatment that is protected by Federal Regulation 42 CRF, Part 2. I specifically authorize disclosure of such information.

_____Release psychiatric and mental health/behavioral health records. Psychotherapy records will NOT be released (this requires a separate release form).

_____Release records concerning testing for and diagnosis of sexually transmitted diseases.

I understand that:

- I may refuse to sign this authorization.
- The original copy of this authorization shall be included with my original records.
- Unless otherwise revoked, this authorization expires _____ (insert applicable date). If no date is indicated, the Authorization will expire 30 days after the date of signature.
- I understand that this authorization will remain in effect until the term of this authorization expires, or I provide a written notice of revocation. The revocation will go into effect immediately upon receipt, except that it will not apply to any action taken by the sending agency before receipt of the written notice of revocation.
- I understand that the person receiving my Protected Health Information (PHI) may not be required to comply with federal and state privacy laws, and my PHI may no longer be protected by the applicable state and federal law once it is disclosed by Inspire Family Medicine, PLLC.
- I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby knowingly and voluntarily, authorize disclosure of the above PHI to the persons or agencies listed above.

Release my protected health information to the following physician person/facility/entity:

Inspire Family Medicine, PLLC

45 Sterling St, Suite 22

West Boylston, MA 01583

Phone: 774-772-5161

***Please send records via Secure Fax to 774-893-8608 or if > 50 pages, send via CD. DO NOT SEND PAPER CO**

Patient Name:

_____

Signature of Patient/Guardian/Authorized Representative:

_____

Today's Date:

_____

_____ _____

Client Signature Date