

Authorization for Release of Outgoing Medical Information

Please complete this form thoroughly. Your medical records cannot be released until this form is completed, signed by the patient or legal guardian and returned to this office.

Step 1	Information about you:		
Please fill in demographic	Patient Name: Date of Birth:		
information.	Address:		
Step 2	Who has the records now?		
This section has been completed for you.	I hereby authorize:	Merrimack Valley Inter 20 Research Place, Suit North Chelmsford, MA Phone: 978-3459-2152	01863
Step 3	To whom do you wish to release your records to? Please send my records to (check one): Myself / New PCP (If New PCP, fill out information below) Name:		
Name and address to send your records to.			
	Address:		
Step 4 Please read and authorize what	If my initials appear here, I authorize the release of ALL RECORDS which include office notes, lab reports, diagnostic imaging, and problem list.		
information is to be	OR		
sent.	Release only the following:		
Step 5 Please read thoroughly, sign and date.	I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric, venereal disease, social service, Hepatitis B testing/treatment, HIV/AIDS testing and/or treatment, and/or any other sensitive information, I am agreeing to the release of this information.		
	Patient Signature/	Legal Guardian	Date
Step 6 Please read thoroughly, sign and date.	I have carefully read and understand the above information, and so herein expressly and voluntarily consent to the disclosure of the above information about, or medical records of my condition to those persons or agencies named above. I hereby release the above named physician and covering physicians from all liability that may arise from the release of my medical records. This authorization will expire 12 months from the date shown below.		
	Patient Signature/	Legal Guardian	Date