Healthcare South, P.C.

www.healthcaresouth.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

Electronic copies of your record are preferred. If you do choose to receive a paper copy, you may be charged.

Patient Name:_____ Date of Birth __/__/__
Last First MI

Address:_____
Street City State Zip

Telephone :_____ Fax:_____

I hereby authorize_____ MD/DMD to release my records.

Physician's Address_____
Street City State Zip

Telephone: _____ Fax:_____

Please release the following information for the purpose of (i.e. – transfer of care, special consultation, etc.)
____**Transfer of Care**_____ All records__**X**__ Dates of Treatment____

Send To **Healthcare South**
340 Wood Road, Suite 101
Braintree, MA 02184
Telephone: (781) 843-0705 Fax: (781) 843-3809

Signature Required
This authorization is valid for 1 year and may be revoked at any time in writing prior to the expiration date. Additional authorization for redisclosure beyond recipient is required.

_____ _____
Patient's Signature Date

_____ _____
Witness Signature Parent/Guardian's Signature (If Patient is a minor)

Release for Sensitive Information – Signature Required
I UNDERSTAND THAT IF MY MEDICAL RECORD CONTAINS INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, SEXUALLY TRANSMITTED DISEASES, SOCIAL SERVICE, HEPATITIS B TESTING/TREATMENT, AND/OR SENSITIVE INFORMATION, I AGREE TO ITS RELEASE.

_____ _____
Signature of Patient or Legal Guardian Date

Release of HIV Information – Signature Required
IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV (AIDS) TESTING/TREATMENT RECORDS RELEASE YOU MUST SIGN AND DATE ON THE LINE BELOW.

I AGREE TO THE RELEASE OF THIS INFORMATION

_____ _____
Signature of Patient or Legal Guardian Date