



Request to Release Medical Records to FMA

This request is directed to the following physician:

Name: Street or PO Box City: State: Zip:

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:

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. Michael Yoon Dr. Meghan Tramontozzi 147 South Main Street ♦ Middleton, MA 01949 ♦ Phone 978-774-2555 ♦ Fax 978-774-8715

Purpose for disclosure:

Changing physicians Continuing care 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 AIDS/ARC Alcohol abuse Substance abuse Infertility studies Mental health visits Sexual abuse/rape Venereal Disease

Other (specify) Release Do not release

Patient signature: Date:

## Signature Page

1. I understand that I may revoke this authorization at any time by notifying \_\_\_\_\_ 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.

\_\_\_\_\_  
Signature of Patient

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent / Legal Guardian / Authorized Person

Date \_\_\_\_\_

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