Acton Medical ASSOCIATES

Adult & Pediatric Primary Care

CONSENT TO DISCLOSE HEALTH INFORMATION
FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

Patient Name: ____
Last First Middle

Home Address: ____
City/Town State Zip

Home Telephone: ______________________ Date of Birth: ______________________

ACKNOWLEDGMENT OF RECEIPT OF AMA'S NOTICE OF PRIVACY PRACTICES:
By my signature below, I hereby acknowledge that I have been provided with a summary of AMA's Notice of Privacy Practices and have access to the full text of AMA's privacy policy.

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION:
By my signature below, I hereby authorize AMA to disclose my medical information so that AMA may treat me, seek payment from third parties for such treatment, and generally carry on AMA's health care operations (e.g. quality assurance). I also authorize AMA to disclose my medical information to insurers and providers outside of AMA when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care options.

_____I authorize AMA to disclose my medical information on my home answering machine/voice mail

_____I authorize AMA to disclose my medical information to the person(s) listed herein:

Name: ______________________________ Phone Number: ______________________

Name: ______________________________ Phone Number: ______________________

My Highly Confidential Information:

I understand that my medical record currently contains or may contain in the future the following types of highly confidential information. By my signature below, I specifically consent to the disclosure of such information as part of my medical record to insurers and providers outside AMA for the purpose of obtaining treatment for me, payment for the treatment provided to me, and so that these entities can carry out their health care operations.

- information about genetic testing
- information related to confidential communications excluding psychotherapist, psychologist, social worker, allied mental health professional, or human services professional
- information about venereal diseases(s)
- mammography records
- information about family planning services
- if I am an emancipated minor, information about my treatment and diagnosis (except to my parents)
- information about research involving controlled substances
- abortion consent form(s)

______________________________ ______________________
Signature of Patient Date

If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally), obtain the following signatures:

______________________________ ______________________ ______________
Signature of Personal Representative | Description of Authority | Date

321 Main Street
Acton, MA 01720-3799
(978) 635-8700

592 King Street
Littleton, MA 01460-1245
(978) 486-9255

231 Ayer Road
Harvard, MA 01451-1100
(978) 772-1213

Administration (978) 635-8800 • www.actonmedical.com