

**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.

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| <ul style="list-style-type: none"> 🔒 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 | <ul style="list-style-type: none"> 🔒 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

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

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

Harvard, MA
231 Ayer Street
(978) 772-1213

