Acton Medical ASSOCIATES
Adult & Pediatric Primary Care

****PLEASE MAIL COMPLETED FORM TO YOUR FORMER HEALTHCARE PROVIDER****

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

Patient Full Name _____ DOB:_____

Patient Address: _____

_____

I hereby authorize Dr. _____of Acton Medical Associates, PC to **obtain** my personal health information from:

Name: _____

Full Address: _____

_____

_____ Office notes **(2 years**); Immunizations; Radiology and diagnostic reports, consults, labs **(5 years**); **ALL** surgical notes, procedure notes and pathology reports

_____ Abstract of entire medical record

_____ Other medical information dating from: _____

Release of Information Requiring Specific Consent: The following categories of information may be included in your medical record. **INITIAL** below if you **DO NOT** want to have this information released:

_____Abortion _____ Behavioral/Mental Health _____HIV/AIDS

_____Alcohol/Drug Abuse _____ Genetic Testing _____Domestic Assault _____STDs

I understand that:

- I may inspect or obtain a copy of the protected health information described by this authorization.
- I may revoke this authorization in writing at any time. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
- Information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to Federal or State law protecting its confidentiality.
- This authorization will automatically expire 90 days from the date set forth below unless otherwise specified: _____(Date of expiration)

I have read and understand the above statements and authorize disclosure of the information requested above:

Signature of Patient (if 18 or over)/ Parent/ Legal Representative Date