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: ______________________________

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: ______________________________

______________________________________ ____________________________
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

Hudson, MA
26 Highland Commons East
(978) 568-1420