Acton Medical ASSOCIATES
Adult & Pediatric Primary Care

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Full Name _____ DOB: _____

Patient Address: _____

_____

I hereby authorize Dr. _____ of Acton Medical Associates, PC to **release** my personal health information from:

Name: _____

Full Address: _____

_____

Reason for Release: ___Insurance Change __ Moving/Moved ___More Convenient Location

___Personal Use __ Appt. W/Specialist ___New Primary Care Physician

___Other (please specify)_____

Information to Release:

_____ Entire Electronic Medical Record (CD) (For Transfer to another physician or personal use) $15.00
_____ Entire Medical Record (paper copy) (For personal user) $25.00
_____ Other (Please be specific) _____

Do you intent to continue receiving primary care from Acton Medical Associates? ❑ yes ❑ no

Release of Information Requiring Specific Consent: The following categories of information may be included in your medical record Please indicate if you authorize release of the following information:

Abortion ❑ yes ❑ no **Behavioral/Mental Health** ❑ yes ❑ no **HIV/Aids** ❑ yes ❑ **no** **STD** ❑ yes ❑ no

Alcohol/Drug Abuse ❑ yes ❑ no **Genetic Testing** ❑ yes ❑ no **Domestic Assault** ❑ yes ❑ no

I understand that:

- I may inspect or obtain a copy of the protected health information described by this authorization.
- Acton Medical Associates, PC will not cause any adverse changes in payment or enrollment in my health plan (if applicable) or refuse to treat me solely because I have refused to sign this Authorization for Use or Disclosure of Protected Health Information.
- I may revoke this authorization in writing at any time by delivering such written notification to the Privacy Officer of Acton Medical Associates, PC. 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

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

RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME