Akwaaba Care
FAMILY PRACTICE

1450 East Street
Suite Seven
Pittsfield, MA 01201
ph 413.728.9801
fax 833.989.2283

Patient Release Form
Authorization to Release Protected Health Information

Name (First, MI, Last)_____

Date of Birth ____/____/____ Mobile phone_____

I, _____, hereby authorize the following facility:
print your name

Name of Practice and Provider_____

Practice Address_____

_____

Office phone_____

Fax number _____

To release my protected health information to Akwaaba Care Family Practice, located at 1450 East Street, suite 7, in Pittsfield, MA 01201.

I have read and understood the information in this authorization.
Patient/Guardian Signature: _____
today's date: _____
Printed Name _____

FAX PATIENT RECORDS TO 833.989.2283