Primary Physician Partners / Partners in Internal Medicine
123 Summer St. Suite 385 N. Worcester, MA. 01608
See attached fee schedule for release of Medical Records. PAYMENT OF $ 25 IS DUE AT TIME OF REQUEST and records will not be released until payment is received.
Tel: 508-363-7300 Fax: 508-363-9688 NO CD'S PLEASE

AUTHORIZATION TO DISCLOSE MEDICAL RECORD INFORMATION

Patient Information: ______________________________ D.O.B.____________

Patient Address: ______________________________ Phone #________________

City: ______________________ State: __________ Zip: ______________

Release Information **I hereby Authorize Primary Physician Partners / Partners in Internal Medicine to:**
☐ Mail my medical records to: ☐ Obtain my medical records from:

Name/ Facility: ______________________________Attn: ________________

Address: ______________________________Phone: ________________

City: ______________________________ State: __________ Zip: ______________

Purpose of request: ☐ Personal ☐ Continuing Care (referral 2nd opinion) ☐ Transfer of Care (new physician)
☐ Legal ☐ Insurance ☐ Other ______________________________
Information to be Released: Please be specific –include dates of treatment and provider's name if applicable

Complete Chart:______________________Date(s): of Treatment ______________________

Other:______________________________Date(s): of Treatment ______________________

Statutorily Protected and Sensitive Information
Your informed consent is required to release records containing the information below. Please check and initial categories which you are authorizing to be released.

☐ Mental Health	Initials: _______	☐ Depression / Anxiety	Initials: _______
☐ Alcohol/Substance Abuse	Initials: _______	☐ Domestic/ Sexual Assault	Initials: _______
☐ HIV	Initials: _______	☐ Genetic Testing	Initials: _______
☐ Sexually Transmitted Disease(s)	Initials: _______	☐Abortion	Initials: _______

I understand that I have a right to revoke this authorization at any time by providing a written statement to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand, unless otherwise revoked or specified, this authorization is valid for 12 months.
Please specify expiration date if other than twelve months: ______________________
I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
Signatures:
Patient /Legal Representative Signature: ______________________________ Date: ______________

If signed by Legal Representative, Relationship to Patient______________________________

Witness Signature: ______________________________ Date: ______________________