# SWIFT RIVER MEDICAL ASSOCIATES
# 35 BRIDGE STREET, SUITE 1
# BELCHERTOWN, MA 01007
# (413) 213-0550 (tel); (413) 213-0554 (fax)

## AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

**Patient Name: _____ Date of Birth: _____**

I hereby authorize **Swift River Medical Associates** to **OBTAIN FROM / DISCLOSE TO** my protected health information:

_____
(insert name of previous PCP or specialist name here)

**Please check all that apply (PAST THREE YEARS ONLY):**

□ All Medical Records □ Labs □ Office Notes □ Imms □ Radiology

□ Other _____

**Reason for request:**

□ Transfer of care
□ Continuation of care
□ Other (i.e., legal, insurance claim, etc.) _____

**Sensitive Information:** I understand that the information in my medical records may include information related to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse. I wish to have this information released as well.

Initials: _____ Date: _____
(if this section is not completed, sensitive information may not be released)

**Right to Revoke:** I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

**Expiration:** Unless otherwise noted, this authorization will expire within 1 year of the date of this release or on this date _____.

_____ Date: _____
Signature of Patient, Parent or Legal Guardian