Milford Regional Physician Group, Inc.
9 Industrial Road, Suite 5 • Milford, MA 01757
Ph: 508-473-1480 • Medical Records Fax: 508-478-0694
Affiliated with Milford Regional Medical Center

Milford Regional Physician Group
The Benchmark for Quality Care

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

Section 1: PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____

Patient Address: Street:_____Apt #:_____City:_____State:_____Zip:_____

Telephone Contact #: Day:_____ Email:_____

Section 2: AUTHORIZATION

FROM (Physician/ Office providing the information):

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

TO (Person(s) organization receiving the information):
PLEASE PROVIDE COMPLETE MAILING ADDRESS

Name: _____

Address: _____

_____

Phone: _____

Section 3: PURPOSE

A. (Please check the appropriate box)

- ☐ I am receiving treatment by a specialist
- ☐ Insurance
- ☐ Legal Matter
- ☐ Personal
- ☐ School
- ☐ Other (please specify) _____

_____

B. I am transferring my care to another healthcare provider

May we ask why you are leaving?

- ☐ Moving
- ☐ Change of insurance
- ☐ Dissatisfied (please explain) _____

_____

- ☐ Other (please specify) _____

_____

Section 4: INFORMATION TO BE RELEASED (Please Select Only 1 Option)

There is NO Charge for:

- ☐ An abstract, patient summary, immunization record, most recent physical, labs and preventative screening.

There IS a charge for:

- ☐ Medical Record – The last three years of the record will be sent.
- ☐ Date Range of_____ to_____

(Cost will vary depending on the requested documents. Invoices will be mailed)

Section 5: CONFIDENTIAL RELEASE

Please answer YES or NO to each of the following questions, to indicate if we may release the information below (if it is in your medical record):

- ☐ Yes ☐ No HIV/AIDS diagnosis and treatment.
- ☐ Yes ☐ No Genetic test results and records relating to any genetic condition.
- ☐ Yes ☐ No Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE IS EXPRESSIVELY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This request may be revoked upon oral or written request.
- ☐ Yes ☐ No Other(s): Please List_____
- ☐ Yes ☐ No Details of Mental Health Diagnosis and/ or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) (*I understand that my permission may not be required to release mental health records for payment purposes).*
- ☐ Yes ☐ No Confidential Communications with a Licensed Social Worker.
- ☐ Yes ☐ No Details of Domestic Violence Victims' Counseling.
- ☐ Yes ☐ No Detailing of Sexual Assault Counseling.
- ☐ Yes ☐ No Details of Sexually Transmitted Disease (includes HPV/Chlamydia).

Incomplete forms will be returned and could delay your request.

Section 6: SIGNATURE

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the office where I originally submitted this authorization. Authorization may be withdrawn except for the following:
  - to the extent that action has been taken in reliance on this authorization
  - If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
- Information released on this authorization, if disclosed by the recipient, is no longer protected by Milford Regional Physician Group, Inc.
- I understand that this authorization will automatically expire in 12 months unless otherwise specified.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above mentioned information about, or medical records of, my condition to those personas or agencies listed above.

Patient's Signature:_____ **Date:**_____

Signature of Legal Representative:_____ **Date:**_____

Print Name:_____ **Relationship of representative to patient:**_____

Please note: Milford Regional Physician Group may charge a fee for copies