Northeast Medical Associates, PC

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Records Release Form

PATIENT IDENTIFICATION

Name (Print) ____

Date of Birth_______/_______/_______________ Social Security_____/_______/________

RELEASE RECORDS TO

Name ____

Address________________________________ City/State/Zip________________________

Phone _________________________________ Fax ______________________________

RECORDS REQUESTED

☐ Labs ☐ X-Rays ☐ Consults ☐ Progress Notes ☐ All
☐ Other ________________________________
____

PURPOSE OF RELEASE

☐ Medical Care ☐ Insurance ☐ Patient Request
☐ Other, please explain ________________________
____

I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS), and/or HIV status.

I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.

I do ________ do not ________ authorize this information to be released. **(You must initial one.)**

Limitations, if any ____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization 60 days from the date signed unless otherwise stated herein.

Signature of Patient/Legal Representative ________________________________ Date ________

Printed Name (If not the same as patient) ________________________________

Relationship to patient ____

THERE WILL BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS THE COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY.