

AUTHORIZATION FOR RELEASE/DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____

Records Out:

I authorize **Danvers Family Doctors, P.C.** to release my health information to the following person/organization:

Name: _____

Address: _____

Records In:

I authorize: _____

To release my health information to:

Danvers Family Doctors, P.C.
140 Commonwealth Avenue, Suite 202
Danvers, MA 01923
Tel#: 978-762-6262 Fax: 978-750-8312

Specific description of information to be released/disclosed (include dates):

Reason for request/description on how information will be used:

Expiration Date of Authorization (90 days unless otherwise indicated):

I understand that I may revoke this authorization (except to the extent that action was already taken in reliance upon it) at any time by notifying Danvers Family Doctors, P.C. in writing. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to receive treatment. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations. I understand that unless I indicate otherwise, this authorization will expire 90 days from the date of my signing it.

Signature of Patient or Legal Representative

Date

Relationship to Patient

Sensitive Information

The above signature **does not pertain** to the following categories. The following protected categories of information will not be released from your record without your signature below. This authorization is only valid for 30 days. Please circle information you would like released and then sign below.

Abortion

Sexually Transmitted Diseases

Hepatitis B Testing/Treatment

Abuse related Information (sexual, physical, alcohol, drug)

Infertility Studies

HIV/AIDS

Sexual Assault

Signature of Patient or Legal Representative

Date

Relationship to Patient