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, PC
1 Roosevelt Ave Suite 204
Peabody, MA 01960

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
Hepatitis B Testing/Treatment
Infertility Studies
Sexual Assault
Sexually Transmitted Diseases
Abuse related Information (sexual, physical, alcohol, drug)
HIV/AIDS

_____

Signature of Patient or Legal Representative Date Relationship to Patient