Medical Record Release Form

Phone: (508) 824-7557
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600 Old Somerset Ave.
P.O. Box 586
North Dighton, MA 02764

Patient Name: ______________________________ **Date of Birth:** ________________

Address: ______________________________________ **SSN#:** ___________________

City: ______________________________ **State:** __________ **Zip:** ________________

Releasing **Practice/Provider Name:** ____

Address: ________________________________ **City:** __________________________

State: ________ **Zip:** ___________ **Ph:** (_______) _______-_________ **Fax:** (_______) _______-_________

Receiving **Practice/Provider Name:** ____

Address: ________________________________ **City:** __________________________

State: ________ **Zip:** ___________ **Ph:** (_______) _______-_________ **Fax:** (_______) _______-_________

Disclose the following information for treatment dates: ______________________________

☐ complete record ☐ office notes ☐ laboratory ☐ x-ray

☐ consult ☐ ER reports ☐ other: ______________________________

Authorized to disclose information relating to (check all that apply):

☐ mental health ☐ genetics ☐ substance use disorder ☐ HIV testing

This information will be used for the following purpose: ______________________________

(ex: medical care, personal, legal, insurance, transferring primary care)

This authorization expires on ____

I do not have to sign this authorization to receive treatment from______________________________;
I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by recipient and may no longer be protected by the HIPAA Rule. I have the right to revoke this authorization in writing Drs. James & Kelly Hoye (address above).

Signed: ____

(Signature of Patient or Legal Guardian) (Relationship to Patient)

Print Name: ______________________________________ **Date:** ________________