Authorization for Use or Disclosure of Medical Record Information

185 West Avenue, Suite 301
Ludlow, MA 01056
Tel:413.583.6750/Fax:413.589.7001

Patient Information:

Patient Full Name: ______________________________ Date of Birth: ______________

Patient Address: ______________________________ Home Phone: ______________

City: ________________ State: ________ Zip: ________ Work Phone: ______________

Release of Information: I hereby authorize Psych Care Associates to:

☐ Mail copies of my Medical Information to: ☐ Hold for Patient Pick-up ☐ Discuss Medical Record Information with: ☐ To obtain my individually identifiable health records from:

Name/Facility: ______________________________ Attention: ______________

Address: ______________________________ Phone: ______________

City: ________________ State: ________ Zip: ________ Fax: ______________

Purpose of Request: ◯ Personal ◯ Continuity of Care ◯ Legal ◯ Insurance ◯ Other

Copy Fee: ***Pursuant to Chapter 135 of the Acts of 2003 "An Act Establishing Reasonable Fees for Copying Medical Records", Mass. Gen. L. ch. 111, §70, we reserve the right to charge a reasonable fee for the cost of producing and mailing the copies.***

Information to be Released: **PLEASE BE SPECIFIC-** include dates of treatment and provider name if applicable:

______________________________ Date(s) of Treatment ______________________________

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Authorization for Release of Statutorily Protected *(sensitive)* **Information:**
Do NOT Leave this Section Blank- The requested medical record MAY contain information that is statutorily protected. Your specific informed consent is required for the release of this information. ☐ Refused ______ Initial

You must check either "yes" or "no" and initial each category in order for your medical record request to be processed.

	Yes	or	No	
Mental Health	☐		☐	Initial Here: __________
Alcohol and/or Substance Abuse	☐		☐	Initial Here: __________
Domestic Sexual Assault	☐		☐	Initial Here: __________

____

Patient's Signature Date

____

Parent/Legally Recognized Representative Signature Date

____

Witness Date