psych care
associates, p.c.

Tel:413.583.6750/ Fax:833.974.2219

Auth for Use & Disclosure of Medical Record Info

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 _____

_____ Date(s) of Treatment _____

_____ Date(s) of Treatment _____

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