



# Authorization For Use or Disclosure of Medical Record Information

Mill City Medical  
595 Pawtucket Blvd  
Lowell MA 01854  
Phone: 978-955-9500 Fax: 978-970-1115

## Patient Information

Patient Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Any other Previous Names: \_\_\_\_\_  
Patient Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

## Authorization to Release

I hereby authorize **Mill City Medical** to (please choose one)  Release my medical information to: \_\_\_\_\_  Obtain information from: \_\_\_\_\_  
Name/Facility: \_\_\_\_\_ Attention: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ Fax: \_\_\_\_\_  
Purpose of Request:  Personal  Referral or 2nd Opinion  Legal  Insurance  Other \_\_\_\_\_  
 Transfer from Practice/Reason? \_\_\_\_\_

## Information to be Released

- Please provide a 2 year abstract of my records
- Other - please be specific, include dates and MD's under comments-

*Comments*

## Authorization to Release Protected Information



**IMPORTANT-** It is extremely important that you select "YES" or "NO" for each selection under the category of **Authorization to Release Protected Information**. Please do not skip any line items as it could impact our ability to fulfill your request and cause additional delays.

- |                              |                          |    |   |
|------------------------------|--------------------------|----|---|
| Yes <input type="checkbox"/> | <input type="checkbox"/> | No | <b>Mental Health Information</b>                |
| Yes <input type="checkbox"/> | <input type="checkbox"/> | No | <b>HIV Tests &amp; Related Information</b>      |
| Yes <input type="checkbox"/> | <input type="checkbox"/> | No | <b>Alcohol and/or Substance Abuse Treatment</b> |
| Yes <input type="checkbox"/> | <input type="checkbox"/> | No | <b>Genetic Testing</b>                          |
| Yes <input type="checkbox"/> | <input type="checkbox"/> | No | <b>Social Worker Communication</b>              |
| Yes <input type="checkbox"/> | <input type="checkbox"/> | No | <b>Sexual/Physical Abuse</b>                    |
| Yes <input type="checkbox"/> | <input type="checkbox"/> | No | <b>Sexually Transmitted Disease (STD's)</b>     |
| Yes <input type="checkbox"/> | <input type="checkbox"/> | No | <b>Other</b> _____                              |

*Other sensitive information?*

Sign Here

Date Here

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date\*

\_\_\_\_\_  
Parent/Legally Recognized Representative Signature\*\*

\_\_\_\_\_  
Date\*\*

Rev. 8/2022

\*This Authorization is valid for 12 months unless you specify otherwise (enter expiration date)\_\_\_\_\_. You may revoke this Authorization at any time by providing a written statement, except to the extent that the provider has already completed action on it.

\*The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem.

\*\* If you are the legally recognized representative of the patient you must provide supporting documentation.

The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. The provider will not condition treatment on payment of the provision of this Authorization.