DOWD MEDICAL ASSOCIATES
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

(*MUST* COMPLETE *ALL* SECTIONS 1-4)

Patient's Name: _____ Date of Birth _____

Contact Phone #: _____

1. **I authorize Dowd Medical to release healthcare information* of the patient named above to:**

Name: _____

This information will be picked up by the individual named above with photo id

2. * Includes Immunizations, 2 years of Office Visits, Specialists Notes, Labs, and Radiology reports

Purpose of Release: ☐Medical Care Coordination ☐ Legal Matter ☐ Insurance ☐ Personal ☐*Transferring Care ☐ Other

*If Transferring Care Reason: Check all that apply
☐ Insurance change ☐ Moving/Planning to move ☐ Location/ closer MD
☐Transfer to Adult Care

3. ***Privileged or Specifically Protected Information. Please circle YES or NO for each of the following.**

The Physicians at Dowd Medical believe that a summary of your complete medical history should be shared with your new provider to ensure the best care. Whether or not you have had testing, diagnosis or treatment for any of the following conditions, please check **YES** if we can release your complete medical record summary to your new medical provider and **NO** if you do not want certain information released. Thank you.

YES- Release my summary medical record, including information from ALL of the below categories.

Or you may choose **NO** for select categories:
NO-Behavioral/Mental Health (including ADD/ADHD/Anxiety/Counseling/Psych notes)

NO-Alcohol/Drug Abuse

NO-HIV, AIDS, STD Results/Treatment/Gyn Notes

NO- Domestic Violence

NO-Rape/Sexual Assault/Pregnancy/Abortion

NO-Genetic Testing

4. **Patient Signature:** _____ **Date Signed**: _____
(Guardian if under 18 years of age)

First copy of Medical Records is free of charge. Second copy of Medical Records is $35 per copy.

For office use:
☐ Chart copied ☐ Give to Nurse/MA_____ ☐ Given to PCP _____ ☐ PCP signed _____
☐ Called patient ☐ Picked-up (Date _____) ☐ Scanned release