DOWD MEDICAL ASSOCIATES Stephanie Batson MD Joan W. Sachs MD 107 Woburn St, Reading, MA 01867 Jennifer Corwin MD Robin A. Smith MD

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient’s Name: | |  | | Date of Birth |  |
| Contact Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **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* | | |

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

1.

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

Other \* NEW Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.

**\*\*\*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 recordsummary to your newmedical 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

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.

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