Authorization to Release Patient Health Information
Please Fax Information if Possible

Patient Name: _____

Date of Birth: ____ / ____ / _____ Phone: _____

Social Security Number: ____ / ___ / _____

I authorize the following doctor / organization to release the information as stated from the patient health information record. I further authorize verbal communication between these stated providers as it relates to my medical care. This authorization covers the time period beginning: ____ / ____ / _____ and ending ____ / ____ / _____.

Information to be released FROM:	**Information to be released TO:**
_____ Organization / Doctor's name _____ Street address _____ City, State, Zip _____ Telephone Number _____ Fax number	Foley Family Practice, P.C. Heidi J Foley, MD 78 Brickyard Road Suite 2 Athol, MA 01331 978-249-7300 Fax: 978-249-5785

Type of records requested

x Full Immunization History x Last Mammogram x Last PAP x Last Dexa Scan x Last Colonoscopy x Last PSA x Last EKG x Last ECHO x Last EST x Last Heart Cath x Last Well Visit x Problem List x Allergy List x Medication List x Surgery List	**Sensitive records require specific patient authorization.** **Please initial the appropriate drug records requested.** **_____ Drug or alcohol abuse** **_____ Mental Health** **_____ Sexually transmitted disease including HIV/AIDS**

Purpose of Need for this information:

x Xfer to a new Provider ☐ **Second Opinion** ☐ **Referral**

☐ **Legal** ☐ **Personal**

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective when Foley Family Practice has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. To revoke an authorization I must write a litter to Foley Family Practice requesting such. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected under federal or state law. I understand that I do not have to sign this authorization in order to get health care benefits. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize the release of patient health information to Foley Family Practice.

____/____/_____ _____ _____

Date **Signature of Patient or legally Responsible party** **relationship to patient**

This authorization is not valid to release future health care more than 90 days from the date signed.