Clear Form

Tewksbury Family Health

A CIRCLE HEALTH MEMBER

Complete connected care℠

Authorization for Release of Outgoing Medical Information

Please complete this form thoroughly. Your medical records cannot be released until this form is completed, signed by the patient or legal guardian and returned to this office.

Step 1 Please fill in demographic information.	Information about you: Patient Name: _____ Date of Birth: _____ Address: _____
Step 2 This section has been completed for you.	Who has the records now? I hereby authorize: **Tewksbury Family Health** **1574 Main Street, Suite 200** **Tewksbury, MA 01876** **Phone: 978-323-2819/ Fax: 978-323-2821**
Step 3 Name and address to send your records to.	To whom do you wish to release your records to? Please send my records to (check one): ☐ Myself ☐ New PCP (If New PCP, fill out information below) Name: _____ Address: _____
Step 4 Please read and authorize what information is to be sent.	If my initials appear here _____, I authorize the release of **ALL RECORDS** which include office notes, lab reports, diagnostic imaging, and problem list. **OR** Release only the following: _____
Step 5 Please read thoroughly, sign and date.	I understand that if my medical record contains information in reference to ***drug and/or alcohol abuse, psychiatric, venereal disease, social service, Hepatitis B testing/treatment, HIV/AIDS testing and/or treatment,*** and/or any other sensitive information, I am agreeing to the release of this information. _____ _____ Patient Signature/Legal Guardian Date
Step 6 Please read thoroughly, sign and date.	I have carefully read and understand the above information, and so herein expressly and voluntarily consent to the disclosure of the above information about, or medical records of my condition to those persons or agencies named above. I hereby release the above named physician and covering physicians from all liability that may arise from the release of my medical records. This authorization will expire 12 months from the date shown below. _____ _____ Patient Signature/Legal Guardian Date