BILLERICA MEDICAL

Internal Medicine- Functional Medicine- Women's Health

AUTHORIZATION TO RELEASE HEALTH INFORMATION FROM BILLERICA MEDICAL

Patient Name:_________________________________ Date of Birth: ___________

(Please print)

Address: _____________________________________

Street Apt. #

____

City, State Zip

I authorize release of the following information:

_____ Complete medical record, or

Clinical summary _____ Test results _____

Consults from others _____

Other (specify) ____

I authorize release of documents that may contain information about:

Alcohol or drug abuse	_____	Blood alcohol test results	_____
Mental Health information	_____	Sexual assault	_____
Venereal disease	_____	Domestic violence	_____
HIV or Aids	_____	Genetic testing	_____
Illegitimate births, abnormal births, fetal deaths			_____

Please release the medical information to:

____

____

____

This authorization will remain in effect for 90 days after the signature date. I understand that I may revoke this authorization at any time by providing this office with a written and signed statement to that effect. I understand that the cost for copying my medical record is $0.25 per page, up to a maximum fee of $20.00 for patients and or to transfer medical care and $50.00 for legal purpose.

_______________________________ _____________

Patient or legal representative signature Date

_______________________________ ____

Printed name of signer, if not patient. Relationship to patient or authority to act for patient

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North Billerica, MA 01862

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