C.B.C Medical & Walk In Center

Internal Medicine- Functional Medicine- Women's Health
16 Pine Street, Unit# 5, Lowell, MA. 01851
Tel: 978-454-9703, Fax: 978-528-2024

AUTHORIZATION TO RELEASE HEALTH INFORMATION
TO
CBC MEDICAL & WALK-IN CENTER

Patient Name:_____ Date of Birth: _____
(Please print)
Address: _____
Street Apt. #
_____
City, State Zip

I authorize _____

_____

_____

to release the following information to: **CBC Medical & Walk-In Center**
16 Pine Street- Unit 5
Lowell, MA 01851

_____ 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			_____

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.

_____
Patient or legal representative signature Date

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