BILLERICA MEDICAL

Internal Medicine- Functional Medicine- Women's Health

Authorization to Release Health Information To Billerica Medical

Patient Name: _____ Date of Birth: _____

Address: _____

_____

I authorize: _____

_____

_____

To release the following information to: ***Billerica Medical***
199 Boston Road
Billerica, Ma 01862

_____ Complete medical records, or
Clinical summary _____ Test results _____
Consults from others _____ Oth(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 birth, abnormal births fetal deaths	_____		

This authorization will remain in effect for 1 year 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.

Signature:_____ Date: _____

199 Boston Road
North Billerica, MA 01862
Ph# 978-670-1300 www.BILLERICAMEDICAL.com Fax# 978-528-2024