Authorization to Release Information (Old Practice)

Last Name: _____ **First Name**: _____ DOB: _____

Home Address: _____

Street *City* *State* *Zip*

Home Phone: _____ **Cell Phone:** _____

I hereby authorize release of my medical records from:

Name (clinic or provider): _____ **Phone #:** _____

Fax #: _____ **Address:** _____

Street *City* *State* *Zip*

Release To:

Wellesley Family Care
Dr. Snider/ Dr. Chodirker/ Dr. Franklin/ Dr. Trapasso/ Dr. Platt
Dr. Carew/Jennifer Snider/Wendy Beaumier/ Colleen Levesque/ David Raymond
Maura Reidy/Kaitlin Lipsky/Jenna Knowlin/Kristin Behenna/Katelyn Kenny/Nina Schussler
145 Rosemary St. Ste. C
Needham, Ma 02494
PH: 781-235-7900
FX: 781-237-9930

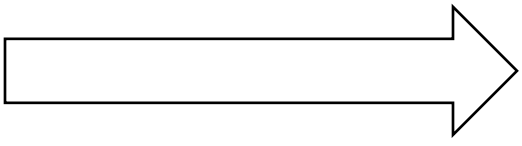
☐ **Release of my medical records** **Treatment Dates:** _____

☐ **Speak or correspond with the above clinician or person regarding my treatment**

☐ **Send via U.S. mail** ☐ **Patient will pick up**

Special Authorization for Release of Statutorily protected information from the medical Record (The following categories of information will NOT be released unless you indicate your specific authorization with your **signature** below)

Mammography Report	
Sexually Transmitted Diseases	
Sexual Assault	
Diagnosis & treatment of Alcohol or Drug Abuse	
Behavioral Health Information	
Domestic Violence	
AIDS/ARC and/or HIV testing results	
Abortion	
Genetic testing and results	



Purpose of Disclosure:

☐ Medical ☐ Legal ☐ Insurance ☐ Personal ☐ Leaving Practice ☐ Other

I understand that once this practice discloses my health information to the recipient, the information becomes the property of the addressee. I further understand that I may refuse to sign or may revoke this authorization for any reason, at any time, and such a refusal or revocation will not affect continuation or quality of my care.

The authorization will be valid for 90 days from the signature date or until: _____

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily authorize Wellesley Family Care to disclose my health information in the manner described above.

Patient Signature: _____ Date: _____

Signature of personal rep/guarantor: _____ Date: _____