Authorization to Release Information (WFCA)

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

Home Address: _____

Street *City* *State* *Zip*

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

I hereby authorize:

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

To:

☐ Release my medical record for the below person/facility

☐ Speak or correspond with the below clinician or person regarding my treatment

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

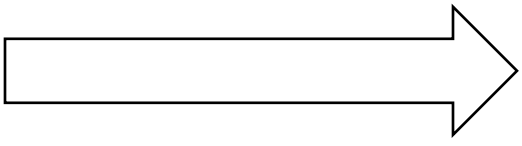
Fax #: _____ Address: _____

Street *City* *State* *Zip*

☐ 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. I understand that Wellesley Family Care will charge a fee for copying and mailing my medical record.

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: _____