



Authorization for Release of Medical Information

Please complete the form thoroughly. Your medical records cannot be released until this form is completed, signed by the patient or legal guardian and returned to this office.

<p>Step 1 Please Print</p>	<p><u>Information about you:</u></p> <p>Patient Name: _____ Date of birth: _____</p> <p>Address: _____</p>
<p>Step 2 Please Print and give us as much information as you may know.</p>	<p><u>Who has the records now?</u></p> <p>I hereby authorize: _____</p> <p>_____</p> <p>_____</p>
<p>Step 3 This Section has been completed for you.</p>	<p><u>To whom do you wish to release your records to?</u></p> <p>Please send my records to: Lung Specialists of the Merrimack Valley 33 Bartlett Street Suite 505 Lowell, MA 01852 Phone: 978-323-0312 / Fax: 978-323-0344</p>
<p>Step 4 Please read thoroughly. Sign and date.</p>	<p>If my initials appear here _____, I authorize the release of ALL RECORDS which include office notes, lab reports, diagnostic imaging, and problem list & immunization records.</p> <p style="text-align: center;"><u>OR</u></p> <p>Release only the following: _____</p> <p>_____</p>
<p>Step 5 Please read thoroughly. Sign and date.</p>	<p>I understand that if my medical record contains information in reference to <i>drug and/or alcohol abuse, psychiatric, venereal disease, social services, Hepatitis B testing/treatment, HIV/AIDS testing and/or treatment</i>, and/or any other sensitive information, I am agreeing to the release of this information.</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">Patient Signature/Legal Guardian Date</p>
<p>Step 6 Please read thoroughly. Sign and date.</p>	<p>I have carefully read and understand the above statement, and so herein expressly and voluntarily consent to the disclosure of the above information about, or medical records of my condition to those persons or agencies named above. I hereby release the above named physician and covering physicians from all liability that may arise from the release of my medical records. This authorization will expire 12 months from the date shown below and may be revoked at any time in writing prior to expiration date.</p> <p>Records released are not for re-disclosure without patient informed consent.</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">Patient Signature/Legal Guardian Date</p>