Family Medical & Maternity Care, PC
87 N. Main St. Leominster, MA 01453 P: (978) 534-8701 F: (978) 534-8705
WWW.FMMCONLINE.COM

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Phone #:** _____

Release information TO FMMC from:	Release information FROM FMMC to:
_____	_____
_____	_____
_____	_____

When requesting records from FMMC:

☐ **I will pick up the records at FMMC**

☐ **I will have another party pick up my records at this office.**
Name: _____

Date range of records: _____**to**_____ **(or)** **Complete Medical Record**

If transferring, reason of transfer: _____

Please review and initial each of the following:

*_____ I voluntarily authorize the release of this protected health information, and furthermore release Family Medical & Maternity Care, P.C. and any other health care facility listed above from any legal liability that may arise from the disclosure or re-disclosure of this information.

*_____ I understand that I may withdraw this authorization by submitting a written revocation to the Medical Records Department, and that this authorization will expire 90 days from the date of signature. I also understand that any written revocation of this authorization will be rendered ineffective if my records have already been released.

*_____ I understand that I am signing this *"Authorization to Use and Disclose Protected Health Information"* release form on a voluntary basis and need not sign this form to ensure healthcare treatment.

In compliance with HIPAA laws please initial next to the following statutorily protected information if you wish to have it included in your medical record. ***(This information will not be released unless specifically authorized.)***

***_____ HIV/AIDS Results** ***_____ Genetic Testing** ***_____ Psychiatric Health**
***_____ STD-Related Information** ***_____ Abortion** ***_____ Substance Abuse (Drug/alcohol) Treatment**

******* This release form is not valid without signature on reverse side *******

Transferring Patients:

- We require a flat fee of $15 for your complete medical record copied to a CD. (documents will be in PDF format) There is a maximum fee of $25 per family for records copied to a single CD.
- If you require a paper copy of your complete medical record there is a per-page charge in addition to the $15 flat fee. Fees are $.50 per page for the first 100 pages and $.25 per page over 100 pages.
- Payment for records must be received at the time of the request. *(Copying fees are in compliance with Massachusetts Law - Chapter 111: Section 70 regarding the inspection and copying of medical records*.)
- If you opt to have your records mailed, the CD will be password-protected. The password will be mailed in a separate envelope on the same date for added security.
- We may require up to two to four weeks to process medical records requests. You may choose to pick up the CD of your records at our office or have it mailed to you or the office of your new primary care provider.

Please note: All requested family member's medical records will be copied to a single CD unless separate CDs are requested below. Please note a $5 fee per additional CD will be assessed.

TRANSFERRING PATIENTS PLEASE NOTE: Your transfer from the practice will be effective as of the date that your records request is signed. It is imperative that you make immediate arrangements for a new primary care physician as all subsequent health care services will be terminated including pending future appointments and medication refills.

I, the undersigned, acknowledge that I have reviewed and understand the content of this authorization form.

* _____ * _____

Signature of Patient or Legal Guardian Date

_____

Printed Name of Party Requesting Records (**if not patient**)

(This portion will be completed when records are picked up in the office.)

Acknowledgement of Receipt of Records

I hereby acknowledge receipt of the requested medical records from Family Medical & Maternity Care, P.C.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name