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: _____

********** OR **********

I would like the records mailed to:
(An additional $10 certified mailing fee applies)

☐ **My home address** ☐ Health Care Facility listed above

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

Purpose of Medical Records Request: _____

If transferring, reason of transfer: _____

Please review and initial 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 *******

Current Patients: When you are in the office you may request a "clinical summary" at no charge. This will include **allergies, current medications, medical history, immunizations, lab results, problem list, and vitals history**. This printed summary will be for your records only as it is not necessarily a sufficient amount of information for another health care provider. We will also provide a paper copy of your last physical exam for free. (If you have an appointment with a specialist as a result of an office visit we will automatically forward all necessary records at no charge.)

Transferring Patients: FMMC charges a flat fee of $15 for a copy of your complete medical record which is a detailed, comprehensive record including everything in the "clinical summary," encounter notes, images, letters, etc. This will be given on CD in PDF format. If you require a paper copy of your record, you may bring the CD to a public print center or an office supply store. There is a maximum copying fee of $25 per family. (plus shipping fee if applicable).

We require two to four weeks to process medical records requests. You may pick up the CD of your records at our office or have it mailed (signature is required) for an additional $10 certified mailing fee. We accept ***cash or credit card payments only*** for medical records (no checks) and payment 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*.)

Please note: All requested family member's medical records will be copied on to one CD unless separate CDs are requested here: _____

TRANSFERRING PATIENTS PLEASE NOTE: **Your transfer will be effective as of the date this form is received by the FMMC Medical Records Department. It is imperative that you make immediate arrangements for a new primary care physician as all subsequent health care services will be terminated including acute visits and medication renewals.**

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