

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. Trapasso / Dr. Platt / Dr. Carew / Dr. Schwartz / Dr. Burney /
Dr. Rex / Dr. Maher / Jennifer Snider / Wendy Beaumier / Colleen Levesque / David
Raymond / Maura Reidy Kaitlin Lipsky / Kristin Behenna / Katelyn Kenny / Nina Schussler /
Katelyn Kenny / Laura Mancuso / Jessica Santiccioli / Jennifer Phan / John Wolfert
145 Rosemary St. Ste. C
Needham, Ma 02494
PH: 781-235-7900
FX: 781-237-9930

To:

☐ Release my medical records for the below person / facility

☐ Speak or correspond with the above 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 & 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 the 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: _____