Authorization to Release Information (Old Practice)

Last Name: _____ First Name: _____ DOB:_____

Home Address: _____

Street City State ZIP

Home Phone: _____ Cell Phone: _____

I hereby authorize Release of my Medical Records from:

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

Fax #: _____ **Address:** _____

Street City State ZIP

Release To:

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 Treatment Dates: _____

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

☐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	

Flip Over

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 in formation
becomes the property of the addressee. I further understand that I may refuse to sign or m ay
revoke this authorization for any reason, at any time, and such a refusal or revocation will n ot 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 be low, I hereby,
knowingly and voluntarily authorize Wellesley Family Care to disclose my health informatio n in the manner described above.

Patient Signature: _____ Date: _____

Signature of personal rep/guarantor: _____ Date: _____