Tri-County Medical Associates, Inc.
9 Industrial Road, Suite 5 • Milford, MA 01757
Ph: 508-473-1480 • Medical Records Fax: 508-478-0694
Affiliated with Milford Regional

Tri-County Medical
The Benchmark for Quality Care

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

PATIENT INFORMATION

Patient Name:_____ Patient Date of Birth:_____

Patient Address: Street:_____ Apt #:_____

City:_____ State:_____ Zip:_____

Telephone Contact #: Day:_____ Evening:_____

E-Mail Address:_____

Physician/office providing the information:

_____

_____

_____

Person(s)/organization receiving the information ***(please provide complete mailing address)***:

_____

_____

_____

PURPOSE

(Please check the appropriate box)

- ☐ I am receiving treatment by a specialist.
- ☐ Insurance
- ☐ Legal Matter
- ☐ Personal
- ☐ School
- ☐ Other (please specify) _____
- ☐ I am transferring my care to another healthcare provider.

  May we ask why you are leaving?

  - ☐ Moving
  - ☐ Change of insurance
  - ☐ Dissatisfied (please explain) _____

    _____
  - ☐ Other

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INFORMATION TO BE RELEASED

There is NO charge for:

☐ Patient summary, immunization record, most recent physical and labs.

There IS a charge for:

☐ Laboratory, X-ray or other Diagnostic Testing for Date(s) of Service: _____

☐ Office Notes for Date(s) of Service: _____

☐ Medical Record - Unless specified, only the last three years of the record will be sent.

Please answer YES or NO to each of the following questions, to indicate if we may release the information below (if it is in your medical record):

OYes ONo HIV/AIDS diagnosis and treatment.

OYes ONo Genetic test results and records relating to any genetic condition.

OYes ONo Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSIVELY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon oral or written request.

OYes ONo Other(s)**:** Please list
Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) (*I understand that my permission may not be required to release my mental health records for payment purposes)*

OYes ONo Confidential Communications with a Licensed Social Worker

OYes ONo Details of Domestic Violence Victims' Counseling

OYes ONo Details of Sexual Assault Counseling

OYes ONo Details of Sexually Transmitted Disease

Incomplete forms will be returned and could delay your request.

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the office where I originally submitted this authorization. Authorization may be withdrawn except for the following:
  - to the extent that action has been taken in reliance on this authorization
  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by Tri-County Medical Associates, Inc.
- I understand that this authorization will automatically expire in 12 months unless otherwise specified:

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____ **Date:** _____

Signature of Legal Representative: _____ **Date:** _____

Print Name: _____ **Relationship of representative to patient:** _____

Please note: Tri-County Medical Associates may charge a fee for copies