WAYLAND PERSONAL PHYSICIANS
Medical Excellence. Individualized Care.

109 Andrew Ave, Suite 203, Wayland MA 01778
P: 508-358-3300 F: 508-358-2300

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
SS#: _____ Patient's phone #: ( ) _____

PURPOSE FOR THIS REQUEST: (Check one.) ☐ Healthcare ☐ Insurance coverage ☐ Personal ☐ Other ☐ Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one.)

☐ All medical records related to a specific illness or injury**.**

_____
Specify illness/injury Date(s) of treatment

☐ Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)

☐ Specific information (Select one or more, as applicable)
☐ Procedure report ☐ History & physical ☐ Physical Therapy ☐ Laboratory test results
☐ X-ray reports ☐ Other _____
(Please describe.)

☐ Entire copy of medical record

AUTHORIZATION VALID FOR:
This request **and** for medical records of any **future** treatment of the type described above until: _____
Insert Date

By checking the boxes below, I authorize that specific health information to be released:

☐ AIDS/HIV ☐Alcohol and/or Drug Abuse Treatment ☐ Mental Health Treatment

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative _____ Date _____

Relationship to Patient *(if requester is not the patient)* _____