Somerville Family Practice
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AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFROMATION
THIS FORM MUST BE COMPLETED IN ITS ENTIRETY AND SIGNED TO BE VALID.
INCORRECT OR INCOMPLETE FORMS WILL NOT BE PROCESSED.

I, (name of patient)_____DOB:_____

Legal guardians name:_____

Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

authorize (Who has records now?)

PROVIDER NAME:
_____

ADDRESS:_____

PHONE:_____FAX :_____

to use and/or disclose my health information as identified below to

NAME OF RECIPIENT: (Name of person or facility to receive medical information.)

_____

ADDRESS:_____

PHONE:_____FAX :_____

for the following purpose(s):
_____Moving
_____Changed Insurance
_____ Request of the individual
_____Other (please describe)_____
By initialing the spaces below. I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:
_____ All office records

_____Billing statements for (dates)_____

_____Other (describe)_____
The following items must be initialed to be included in the use or disclosure of other health information:
_____ HIV/AIDS related health information and/or records
_____ Venereal disease records
_____ Mental health information and/or records
_____ Genetic testing information and/or records
_____ Drug/alcohol diagnosis, treatment, and/or referral information.
Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.

Signature:_____Date:_____
Expires 90days after the date this form is executed.