Milford Regional Physician Group, Inc.

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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:	Date of Birth:
Address:Ap	ot#:Zip:
Phone: Email	l:
<u>AUTHORIZATION</u>	
FROM (Physician/Office providing the information):	TO (Person/Organization receiving the information):
Send this completed form to this location listed below	Please provide complete mailing address
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax/Email:
<u>A</u> <u>PURPOSE</u>	B Information to be Released
I am receiving treatment by a specialist Transfer of Care to New Provider Legal Matter Personal Insurance Other (specify)	Abstract Transfer of Care (recommended for New Provider) Note: selecting this option may result in a fee: Other (specify):
CONFIDENTIAL PROTECTED INFORMATION	
By signing below, I understand that this consent may include the disclosure of: HIV/AIDS diagnosis & treatment, alcohol and/or drug abuse records, sexually transmitted disease records, and genetic test results. I authorize the release of all my medical records except :	
I understand: 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 Authorization may be withdrawn except for the following: to the extent that action has been taken in reliance on this authorization or if the authorization is obtained as a condition of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 disclosed by the recipient, is no longer protected by Milford Regional Physician Group, Inc. I understand that this authorization will automatically expire in 12 months unless otherwise specified.	
Patient/Parent Signature:	Date:
Signature must be: Hand written or digitally signed (typed font not accepted)	
*Legal documents must be attached if not signed by the patient	
Signature of Legal Representative: Date:	
Print Name: Relationship of Representative to Patient:	



FREQUENTLY ASKED QUESTIONS

Once I complete this form where do I send it?

If you are requesting records from an MRPG provider/location, you can fax, email or mail the form to the address listed on the top left corner. If you are requesting records from another provider (not MRPG) send the form directly to that provider's office.

What information is included in the Abstract Transfer of Care option?

We offer a comprehensive Transfer of Care option at no charge that is recommended for transferring care to a new provider. It includes: Chart summary (list of diagnosis, allergy information & immunizations), last physical/acute visit, lab flowsheet, preventative screening (colonoscopy, pap smear & mammograms), recent imaging (CT, MRI etc.), and recent consultation records.

Who can sign the release form?

Patients are required to sign their own release form. Patients that are minors, Parents will need to sign release form. All other signatures must have legal documentation to support signing on behalf of the patient. (Ex: Guardianship papers)

*Please note: all signatures must be hand written or digitally signed. Typed font is not accepted.

I am the Health Care Proxy for my loved one can I sign the release form?

We only accept the signature if the following requirements are met: Health Care Proxy must be invoked by the Provider (documentation required) and can only be used to transfer records to another Provider for continuity of care.

How do I obtain copies of radiology images?

You will need to contact Milford Regional Medical Center at (508) 473-1190 and follow the prompts for Radiology.

Is there a cost to obtain my complete record?

The cost will vary depending on the request. We reserve the right to charge a reasonable cost-based fee for producing and mailing the copies according to HIPAA 45 CFR, 164.254. We do offer email delivery at no charge.

For more information visit our website at www.milfordregionalphysicians.org The Medical Records page is listed under the About tab.