**Milford Regional Physician Group, Inc.**
9 Industrial Road, Suite 5 • Milford, MA 01757
Ph: 508-473-1480 • Medical Records Fax: 508-478-0694
Email: MRPG-medicalrecords@milreg.org
**Affiliated with Milford Regional Medical Center**

**Milford Regional Physician Group**
*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.

## Section 1: PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____

Patient Address: Street:_____Apt #:_____City:_____State:_____Zip:_____

Telephone Contact #: Day:_____ Email:_____

## Section 2: AUTHORIZATION

**FROM (Physician/Office providing the information):**

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

**TO (Person/organization receiving the information):**
**PLEASE PROVIDE COMPLETE MAILING ADDRESS**

Name: _____

Address: _____

_____

Phone: _____

## Section 3: PURPOSE

**A. Please check the appropriate box**

- ☐ I am receiving treatment by a specialist
- ☐ Insurance
- ☐ Legal Matter
- ☐ Personal
- ☐ School
- ☐ Other (please specify) _____

_____

**B. I am transferring my care to another healthcare provider**

May we ask why you are leaving?

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

_____

- ☐ Other (please specify) _____

_____

## Section 4: INFORMATION TO BE RELEASED (Please Select Only 1 Option)

There is **NO CHARGE** for:

____ Transfer of Care

OR

There **IS A CHARGE** for:

___MRPG Medical Record - Designated record set for last 3 years.

___Date range of _____to_____

___Other _____

**Invoice Options:** (Choose 1 ~~ Please print clearly!)

Mail ____

Email _____

***Cost will vary depending on documents requested***

**Complete Pages 1 & 2**

## Section 5: CONFIDENTIAL RELEASE

*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):*

☐ Yes ☐ No HIV/AIDS diagnosis and treatment.

☐ Yes ☐ No Genetic test results and records relating to any genetic condition.

☐ Yes ☐ No Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2
(FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE UNLESS EXPRESSLY PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This request may be revoked upon oral or written request.

☐ Yes ☐ No Other(s): Please list_____

☐ Yes ☐ No Details of Domestic Violence Victims' Counseling.

☐ Yes ☐ No Detailing of Sexual Assault Counseling.

☐ Yes ☐ No Details of Sexually Transmitted Disease (includes HPV/Chlamydia).

*Incomplete forms will be returned and could delay your request.*

## Section 6: SIGNATURE

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 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.

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 mentioned information about, or medical records of, my condition to those personas or agencies listed above.

**Patient's Signature:**_____ **Date:**_____
***Handwritten signature - typed font not valid**

**Signature of Legal Representative:**_____ **Date:**_____
*Legal documents must be attached if not signed by patient.*

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

**Please note: Milford Regional Physician Group may charge a fee for copies**

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