DRACUT FAMILY
HEALTHCARE, LLC
155 Broadway Road • Suite 6 • Dracut, MA 01826 • phone 978.458.0475 • fax 978.458.3574
Taking Care of *All* of You

Authorization to Release Protected Health Information

Patient Name: _____ D.O.B._____

Address: _____ Phone #:_____

I hereby authorize: _____
(Name of provider/persons making the release)

to disclose my Protected Health Information to:_____
(Name of provider/persons to whom PHI is being released)

for the purpose of:_____
(Reason information is being disclosed)

Information to be disclosed should include: _____
(Specific information to be released)

Dates of treatment included: _____to_____

This authorization expires on:_____
(If no date is stated, this authorization expires 6 months from date signed)

1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
2. I understand that if I do not sign this form, my health care will not be affected.
3. I understand that I may revoke this authorization at any time in writing, but I understand that this will have no effect on information previously authorized to be released.
4. I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Sensitive Information: By my signature below, I understand and authorize the release of information such as sexually transmitted disease, HIV status, AIDS information, mental health care and treatment, alcohol abuse and drug abuse that may be contained in my medical records.

__/__/__ _____ _____
Date Signature of patient or repesentative Relationship to patient