Charles River
Medical Associates

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize Charles River Medical Associates to:

☐ **Release my medical records to be picked up at the office**

☐ **Release my medical records to**: ☐ **Obtain my medical records from:**

Name/Facility: _____

Address: _____ Phone: _____Fax:_____

City: _____State: _____Zip:_____

I authorize release of all my medical records except those checked below:

☐ HIV/AIDS diagnosis and treatment ☐ Genetic test results

☐ Alcohol and Drug Abuse Records ☐ Psychiatric Health including Behavioral Medicine

☐ Sexually Transmitted Diseases ☐ Other: Please list_____

I understand:

- I may withdraw my authorization at any time by submitting a written request to the office where I originally submitted the authorization (except to the extent action has already been taken 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.)
- Authorizing disclosure of health information is voluntary. I do not need to sign this form in order to assure treatment.
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by Charles River Medical Associates.
- This authorization will expire on_____(specify date) or, if no date is specified, automatically expire in 12 months from the date of signing.

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

Patient's Signature:_____

Print Name:_____Date:_____

When a patient is a minor, or not competent to give consent, the signature of parent, guardian or other legal representative is required.
Signature of Legal Representative: _____

Print Name: _____

Relationship of Representative to Patient:_____