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PLEASE NOTE THAT THIS FORM MUST BE FULLY COMPLETED WITH ALL INFORMATION BEFORE ANY MEDICAL RECORDS CAN BE RELEASED. INCOMPLETE INFORMATION WILL RESULT IN THE FORM BEING DEEMED NULL AND VOID. THIS REQUIREMENT IS FOR MATTERS OF PATIENT CONFIDENTIALLY.

Authorization for Disclosure of Medical Information

Name: _____ MGH # _____

Date of Birth: _____ Social Security Number _____

Patient's Home Address: _____

_____

I hereby authorize release of information from my medical record to:

_____
(Name)

_____
(Address)

_____

This Authorization covers the following records: (Please check those applicable)

____ Records only for my treatment of: _____

____ Records for dates of service from _____ to _____
Month/Year Month/Year

____ No limitation on medical and/or psychiatric treatment, history of illness or related information obtained.

____ Any treatment for alcohol and/or drug abuse (initial if applicable _____). This authorization is valid for the attached request only and will not be honored for any subsequent requests. I understand that I may revoke this authorization at any time.

This authorization expires one year from the date signed.

Signature of patient: _____ Date: _____

Authorization received by: _____