Signature Medical Group (SMG)
Correspondence Dept.
110 Liberty Street
Brockton, MA 02301
(P) 508-894-0717 (Fax) 508-565-0168

Date Needed: _____

MRN: _____

Authorization for Release of Medical Record Information

Please review and complete the entire form. Your medical records cannot be released until this form is completed, signed by the patient or legal representative and returned to the SMG Correspondence Department.

1. I hereby authorize Signature Medical Group to release information from the medical record of:

Patient Name: _____ Date of Birth: _____
(First Name) (Middle Initial) (Last Name)

Patient Address: _____
(Street) (City) (State) (Zip Code)

Daytime Phone #_____Cell Phone #_____

2. What records do you wish to obtain copies of?

☐ Name of Physician _____ ☐ Office Location: _____

☐ Last 2 Years ☐ Complete Record

☐ Treatment dates from _____ to _____

3. Please select type of information to be released:

☐ ED Report(s) ☐ Consultation Report(s) ☐ Discharge Summary(s) ☐ Operative Report(s) ☐ Immunization Records

☐ Clinical/Office Note(s) ☐ Laboratory Report(s) ☐ Radiology Report(s) ☐ Outpatient Report(s) ☐ Other_____

4. I authorize Signature Medical Group to release copies of the specified information in my medical record to:

_____
(Name) (Complete Mailing Address)

I understand that information used or disclosed pursuant to this authorization could be subject to **re-disclosure** by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I know that this authorization is voluntary. I understand that treatment will not be conditioned on the completion of this authorization.

5. Purpose of Request:

☐ Treatment ☐ Changing PCP ☐ Personal Copy ☐ Disability ☐ 2nd Opinion ☐ School Immunization Record

☐ Moved Out of Area ☐ Temporarily Out of Area ☐ Legal ☐ Insurance ☐ Due to Referral Policy

☐ Other _____

I understand that this authorization is valid for 12 months from the date it was signed OR as of the date specified here __/__/__. If no other date is specified, this authorization will expire 12 months from the date it was signed. This authorization may be revoked in writing by me or my legal representative at any time prior to the expiration date. **A fee will be charged for requests for personal copies.**

Signed: _____ _____
(Patient or Legal Representative) (Date)

SIGNATURE HEALTHCARE
SIGNATURE MEDICAL GROUP

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Privileged or Specifically Protected Information

Please check YES or NO for each of the following questions:

YES NO

☐ ☐ **HIV/AIDS diagnosis and/or treatment:**

I specifically give permission to share information in my record about my HIV/AIDS diagnosis and/or treatment information. Initial here to specifically authorize it release _____ as required by M.G.L. c.111, § 70F.

Signed_____ _____
(Patient or Legal Representative) (Date)

YES NO

☐ ☐ **Genetic Testing:**

I specifically give permission to share information in my record about my genetic testing (excludes therapeutic genetic tests). Initial here to specifically authorize its release _____ as required by M.G.L. c.111, § 70G**.**
(We do not disclose genetic information for Insurance Underwriting purposes).

Signed _____ _____
(Patient or Legal Representative) (Date)

Privileged or Specifically Protected Information

I understand my medical record contains information relating to the subjects I have checked below and agree to the release of this information. **Please check Yes or No for each of the following if applicable.**

YES NO

☐ ☐ Alcohol or Drug Abuse Treatment
☐ ☐ Psychological Treatment
☐ ☐ Rape Victim Counseling
☐ ☐ Treatment of Sexually Transmitted Diseases
☐ ☐ Abortion
☐ ☐ Counseling by a Social Worker
☐ ☐ Domestic Violence Counseling

SIGNED: _____ _____
(Patient or Legal Representative) (Date)

Please Note: If the individual signing the authorization form is a Guardian, Executor of the Estate, Healthcare Proxy or Power of Attorney for the patient, that person must submit a copy of the appropriate legal document, which proves authority to act on behalf of the patient. (**This must accompany the authorization form)**