

Please send completed form to:
35 Millbury Street, Auburn, MA 01501
(508) 721-1142 • Fax: (508) 832-2789

Completed by (For office use only): MRN: _____
Initials: _____ Dept: _____ Date: _____

Patient Information

Patient's Name: _____
Patient's Address: _____ D.O.B: _____
City: _____ State: _____ Zip: _____ Phone #: () _____

Release Information

I hereby authorize Fallon Clinic to:

- Mail my medical records to:** **Obtain my medical records from:**

Name/Facility: _____ Attention: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Fax: _____
Purpose of request: Personal Continuing care (referral/2nd opinion) Transfer of care (new physician)
 Legal Insurance Other: _____

Information to be Released

Please refer to the website for Frequently Asked Questions (FAQ) sheet for information regarding fees. Requests for Radiology Images/Films or billing information must be made directly to each of those departments.

**Please specify date ranges.*

- Abstract (includes immunization, 2 years of office visits and labs, and 5 years of radiology and diagnostic reports and consults - capped at \$25 fee.)
 Office Visits * _____ to _____ Specify Provider(s): _____
(If not specified, all visits with all Fallon Clinic providers during this period will be released.)
 Lab Results: * _____ to _____ Radiology Reports: * _____ to _____
 Other (please be specific): _____

Statutorily Protected Information

The following items will not be included unless specifically authorized.

- | | |
|---|--|
| <input type="checkbox"/> Abortion Inital: _____ | <input type="checkbox"/> HIV/AIDS Results Inital: _____ |
| <input type="checkbox"/> Alcohol/Drug Abuse Treatment Inital: _____ | <input type="checkbox"/> Psychiatric Health-including Behavioral Medicine Notes Inital: _____ |
| <input type="checkbox"/> Genetic Testing Inital: _____ | <input type="checkbox"/> Sexually Transmitted Diseases Inital: _____ |

I understand that I have a right to revoke this authorization at any time by providing a written statement to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand, unless otherwise revoked or specified, this authorization is valid for 90 days.

Please specify an expiration date if other than 90 days: _____.

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that my health record may contain general information related to my mental health, drug/alcohol abuse, or other information that I may consider sensitive. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Signatures

Patient/Legal Representative Signature: _____ Date: _____
Print Name of Patient/Legal Representative: _____
If signed by Legal Representative, Relationship to Patient: _____

This authorization must be completed in its entirety or it will not be processed.



**GENERAL LAWS OF MASSACHUSETTS – PART I.
ADMINISTRATION OF THE GOVERNMENT – TITLE XVI. – PUBLIC HEALTH**

CHAPTER 111. PUBLIC HEALTH – HOSPITALS

Chapter 111: Section 70 Records of hospitals or clinics; custody; inspection; copies; fees

S.B. 642, an Act Regarding Medical Record Copying Fees was signed into law by Governor Romney on November 26, 2003 and took effect on July 1, 2004. This bill identifies reasonable fees and establishes acceptable charges for health information that will comply with both federal HIPAA and state regulatory requirements. The term reasonable fee established under this section may be adjusted to reflect the consumer price index (CPI) for medical care services, such that the base amount and the per page charge shall be increased by the proportional CPI in effect as of October of the calendar year in which the request is made, rounded to the nearest dollar.