HARVARD Family MEDICINE

233 Ayer Road, Suite 10 • Harvard, MA 01451
(978) 772-0698 • (978) 772-0024 (FAX)
info@HarvardFamilyMedicine.com
HarvardFamilyMedicine.com

Authorization for the Release of Protected Health Information

Patient Last Name:_____ First Name: _____ M.I.:_____

Maiden or Other: _____

Date of Birth:_____ Social Security Number:_____

Phone Number: _____ Gender: M ☐ F ☐

I hereby authorize Harvard Family Medicine and its duly authorized agents and employees to

☐ **Release To** **or** ☐ **Obtain From**

Name of Individual / Facility / Company:_____

Address: _____

Phone Number: _____

Information Required:

☐ Complete Medical Records

☐ Other (Specify):_____

This Information For The Following Purpose:

☐ Insurance ☐ Continued Treatment ☐ Attorney

☐ Other (Specify):_____

The information authorized for release may include information which may indicate the presence of a communicable or non-communicable disease.

I understand that I may revoke this consent at any time, and that upon fulfillment of the above stated purpose or the lapse of twelve (12) months from the date of signature, whichever comes first, this consent will automatically expire without my express revocation, but that revocation may not be applied retroactively once the information has been released in good faith. I do not authorize further release to any third party, I understand that Harvard Family Medicine and its staff, employees, officers, and directors cannot be responsible for confidentiality of information disclosed after said information has been released pursuant to this authorization, and hereby release them from any liability arising from such disclosure and from all legal responsibility or liability that may arise from this authorization.

_____ _____

Signature of Patient / Legal Guardian Date

If the patient is deceased, attach a copy of the death certificate or a consent form given by an executor, administrator, or other personal representative appointed under applicable state law.