



Medical Records Correspondence Center
 Harvard Vanguard Medical Associates
 152 Second Avenue, Needham, MA, 02494
 Tel: 617-629-6425 Fax: 617-629-6223
 This location is not accessible to patients

Authorization to Release Medical Records

Patient's Name: _____ Date of Birth: _____
 (Please Print)

Address: _____
 Street City State Zip Telephone No.

I hereby authorize Harvard Vanguard Medical Associates to release protected health information, including copies of the medical record of the above-named patient, to the following person or facility:

 Name of Person or Facility Telephone No.

 Street City State Zip

Purpose of Release: *(Processing fees may apply)*

Medical Care
 Legal
 Insurance
 Personal
 Leaving HVMA
 Other: _____

Information to be released: *Requests for Pharmacy, Dental, Radiology & Billing information must be made directly to that Department.*

Dates of Treatment to be Released: _____ to _____

Laboratory Result
 X-ray (Reports Only)
 Office Notes: _____
 Immunization Record
 Complete Record
 Specify Clinician(s)
 Other: _____

Release of Information Requiring Specific Consent

The following categories of information may be in your medical record and **WILL NOT** be released unless you indicate your specific authorization by checking and initialing each appropriate category.

_____ Abortion
 _____ Behavioral/Mental Health
 _____ HIV/AIDS Results/Treatment
 _____ Alcohol/Drug Abuse
 _____ Domestic Violence
 _____ Rape/Sexual Assault
 _____ Genetic Testing
 _____ Sexually Transmitted Diseases

I understand that:

- I may refuse to sign this authorization. I understand that my refusal will not affect my ability to obtain treatment at Harvard Vanguard Medical Associates unless (a) the only purpose of the treatment is to create health information for the disclosure listed above; or (b) if my treatment is related to participation in a research study for which this authorization is required.
- I may revoke this authorization at any time by submitting a written notice of revocation to at Harvard Vanguard Medical Associates at the address listed above. The revocation will be effective upon at Harvard Vanguard Medical Associate's receipt of my written notice, except that it will not have any effect on any action already taken by at Harvard Vanguard Medical Associates in reliance on this authorization.
- Once Harvard Vanguard Medical Associates has disclosed my health information to the recipient, Harvard Vanguard Medical Associates cannot guarantee that the recipient will not redisclose my health information to a third party.
- This authorization will automatically expire 90 days from the date set forth below unless otherwise specified: _____
 (Date)

 Signature of Patient or Authorized Representative

 Date

 Printed Name of Patient or Authorized Representative

 Relationship to Patient

THIS AUTHORIZATION MUST BE COMPLETED IN ITS ENTIRETY OR IT WILL NOT BE PROCESSED!