Authorization for Release of Medical Information

Patient Name: _____DOB: _____
Phone Number: _____

Please forward copies of my medical records from:

Practice / Physician Name	
Address	
Phone	
Fax	

Please send my records to:

Practice: Falmouth Women's Health
Physician: Dr. Heywood / Dr. Speed
Address: 133 Falmouth Rd. 2A, Mashpee, MA 02649
Phone: 508-681-5081
Fax: 877-669-1746

Purpose of Release: Changing Physician
Release the following: [ ] General Medical Records
[ ] Last Pap
[ ] other_____

Protected or sensitive information: I understand that protected health information cannot be released without specific authorization as required by State / Federal law. By checking the boxes below, I authorize the release of the following protected or sensitive information about me to carry out treatment, payment, and health care operations.
[x] Drug abuse diagnosis / treatment [x] Alcoholism diagnosis / treatment [x] AIDS / HIV test results including related high-risk behaviors [x] Sexually transmitted diseases [x] Mental health treatment [x] Genetic testing

Patient authorization to release information:
I have read and understand the terms of this authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature below I hereby, knowingly and voluntarily, authorize the above the facility / health care provider to disclose my health information in the manner described above. This authorization will be valid for 90 days from the signature date.

Patients Signature: _____ Date:_____
(or) Signature of Legal guardian: _____Date:_____