WE DO NOT ACCEPT ELECTRONIC RECORDS

Authorization for Release of Information

I hereby authorize _____ to disclose the Protected Health Information of:

_____, _____
Patient Name DOB

_____, _____
Street Address City, State, ZIP Code

To: Alan Bulotsky, MD & Associates, PC, 201 Quincy Street, Brockton, MA 02302

Please indicate the information to be released:

____Medical History	____Laboratory Reports	____Surgical Reports	____Immunization Records
____Examination Reports	____Hospital Reports	____Prescriptions	____Consultations
____Treatment Plans	____Accident Reports	____Allergy Records	____Other (please describe below):
____Treatment Tests	____Xray Reports	____Developmental Disabilities	

_____

Please describe the purpose for which you are authorizing your Protected Health Information be used or disclosed:

____Personal Copy ____Transfer ____Treatment ____Other:_____

This authorization will remain in effect until the following date and/or event:_____

I understand that I have the right to revoke this authorization at any time by giving written notice to the Privacy Officer, except to the extent that the person or entity listed above has already made reference to this authorization.

I understand that my healthcare provider may not condition treatment on my authorization to use or disclose this information unless the treatment is research-related or necessary for the purpose of creating protected health information for disclosure to a third party (e.g., Physical exams for school, camp and insurance purposes).

I understand that the health information disclosed as a result of this authorization may be subject to redisclosure by the recipient and no longer be protected by the federal privacy standards (HIPAA).

I have received a copy of this authorization for my records.

_____ _____
Signature Date

If signed by Parent, Guardian, or Legal Representative:

_____ _____
Print Name Relationship to Patient

SIGN ONLY IF APPLICABLE

Release for Sensitive Information:
I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric, veneral disease, social service, hepatitis B testing/treatment, and/or sensitive information, I AGREE TO ITS RELEASE.

_____ _____
Signature Date

Release of HIV Information:
In addition to the above signatures, if you want your HIV (Aids) testing/treatment records released you must sign and date on the line below.
I AGREE TO THE RELEASE OF THIS INFORMATION.

_____ _____
Signature Date

THIS AUTHORIZATION WILL BE INVALID UNLESS ALL REQUIRED ITEMS ARE COMPLETED