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PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Doctor: ____

Patient: ____
(First Name) *(Middle Name)* *(Last Name)*

Date of Birth: ______________________________

Newton Wellesley Surgeons is Authorized to ❐furnish to ***OR*** ❐obtain from

Recipient: ____

Address: ____

Phone: ____________________________ Fax: ________________________

For the purpose of: ____
(Optional)

Medical Records (Excluding Sensitive Information)

❐ Information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with my condition or disease beginning ___/____/____ and ending ___/____/____ and, if necessary, allow them or any physician appointed by them to examine any x-rays or other diagnostic records which the facility may have regarding my condition or treatment during this period.

❐ Only those specific records as described below: ____
____

Sensitive Information:

❐ I hereby specifically _____ consent to or _____ refuse the disclosure and release of "sensitive medical information: concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug abuse/dependency, venereal disease, sexual assault, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, if any.

I release Newton Wellesley Surgeons, Inc. from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Newton Wellesley Surgeons, Inc., provided that I do so in writing and to the extent that Newton Wellesley Surgeons, Inc. may have already disclose the information in reliance on this authorization.

This authorization expires on ___/____/____. *(Optional If no authorization is given then this authorization shall remain in effect for a period reasonable need to complete the request.)* I understand that I have the right to revoke this authorization by notifying Newton Wellesley Surgeons, Inc in writing. I understand that any previously released information would not be subject to my revocation request.

____ ________________________
Patient Signature (Parent if Representative is a minor) *Date*

____ ________________________
Witness Signature *Date*