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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 appointment by them to examine and 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 you do so in writing and to the extent that we 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*