Atrius Health
Part of Optum®

Patient Instructions and Information:

- Please complete this form and mail to former healthcare provider to request a copy of your medical record.

Please be aware that medical record copy fees may apply and contacting your former healthcare provider for specific medical record processing details is recommended.

Authorization to Obtain New Patient Medical Records

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

Address: _____
Street City State Zip Telephone No.

I do hereby, authorize _____
Name of Physician , Facility or Person

Located at _____
Street City State Zip

to release protected health information, contained in the medical record of the above-named patient to the following :

Dr._____
Atrius Health

_____
(Street address)

_____
(City, State, Zip)

Special Authorization for Release of Statutorily Protected Information from the Medical Record

I understand the following categories of information may be in the medical record and ***SHOULD NOT*** be released unless specifically authorized as indicated by my checking and initialing each appropriate category.

❑ ____ Abortion	❑ _____ Behavioral/Mental Health	❑ _____ HIV/AIDS Results/Treatment
❑ ____ Alcohol/Drug Abuse	❑ _____ Domestic Violence	❑ _____Child/Elder/Disabled Abuse
❑ ____ Rape/Sexual Assault	❑ _____ Genetic Testing	❑ _____Sexually Transmitted Diseases

Information to be released:

Dates of Treatment to be Released: _____ to _____ ❑ Laboratory Result ❑ X-ray (Reports Only)

❑ Office Notes: _____ ❑ Immunization Record ❑ Complete Record
Specify Clinician(s)

❑ Other: _____

Purpose of Release: ❑ Medical Care ❑ Other: _____

I understand that once this health information is disclosed, the releasing facility cannot guarantee that the recipient will not redisclose my health information to a third party. Such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke this Authorization in writing at any time and for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment. I understand that this authorization will expire 90 days from the date of said authorization unless I provide a written notice of revocation to the releasing facility noted above.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Printed Name of Patient or Authorized Representative Relationship to Patient