



Dedham Medical Associates  
Granite Medical Group  
Harvard Vanguard Medical Associates  
PMG Physician Associates

**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 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

\_\_\_\_\_

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.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> _____ Abortion            | <input type="checkbox"/> _____ Behavioral/Mental Health | <input type="checkbox"/> _____ HIV/AIDS Results/Treatment    |
| <input type="checkbox"/> _____ Alcohol/Drug Abuse  | <input type="checkbox"/> _____ Domestic Violence        | <input type="checkbox"/> _____ Child/Elder/Disabled Abuse    |
| <input type="checkbox"/> _____ Rape/Sexual Assault | <input type="checkbox"/> _____ Genetic Testing          | <input type="checkbox"/> _____ 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