COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF CORRECTION
HEALTH SERVICES DIVISION

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

PATIENT'S NAME:_____SS#_____

ID#_____DATE OF BIRTH_____

INSTITUTION:_____

_____To provide me with a complete copy/abstract of my medical record for my personal use. I agree to accept responsibility for payment of any fees charged for this service. Provide dates of service.

DATE OF TREATMENT _____
INFORMATION REQUESTED _____

____To allow _____who is _____
(Name of authorized person) (relationship, e.g., physician, attorney)
to be furnished a complete copy/abstract of my medical record.
Provide dates of service _____
(Specify scope of procedures or N/A)

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

I hereby acknowledge that I have read, or have had read to me, and fully understand the above statements as they apply to me and do herein expressly and voluntarily consent to disclosure for the purpose or need and to the extent or nature as stated. I further understand that I may revoke this consent at any time. Except where disclosure has already been made or upon occurrence of the event: the purpose for which this disclosure is hereby authorized. Deletions may be made as required by the privacy laws of Massachusetts.

This Authorization for Release of information (unless expressly revoked earlier) expires sixty (60) days from the date last signed by the patient or authorized agent.

Patient's signature_____Date_____

Witness signature _____Date_____

Copied _____pages @_____Total Paid $_____
 # pages Price per page
_____Date_____
Additional Signature & Relationship to inmate, if required

_____Date_____
Witness

If inmate is deceased, please provide proof of executor or administratix.