longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

YOUR RIGHTS:
I understand I have the right to inspect or copy the health information; I have to be authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies by calling the privacy officer at MSFP. I further understand that there may be a fee for copying my medical information and the copying of this information will be preformed within a reasonable time frame, but not on demand. I understand that if I agree to sign this authorization, which I am not required to do, I have a right to receive a copy of this form. I understand that I have a right to refuse to sign this form, and that I am under no obligation to sign this form and that the person(s) and/or organization listed above who I am authorizing to use and/or disclose my information may not condition treatment on my decision to sign this authorization. I understand I have a right to withdraw this authorization and that written notification in necessary to cancel this authorization. I am aware that my withdrawal of this authorization will not be effective if action has already been taken on this authorization.

Expiration Date:
This authorization will expire on _____ (if left blank 6 months after this form is signed).

I have had and an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that is accurately reflects my wishes.

SIGNITURE OF PATIENT/PARENT/LEFGAL REPRESENTATIVE: **DATE:**

If signed by other than patient state authority to do so i.e. parent/guardian

We require special permission to release otherwise privileged information, please release records pertaining to: (please initial each space you would like to release and sign full name where indicated)

___ Mental Health /Psychiatric
___ HIV/AIDS/AID Related Illness
___ Drug and Alcohol dependency/information
___ Sexually Transmitted Diseases (except as required by Law –we will comply without your consent)
___ other_____

For the following dates: _____

SIGNITURE OF PATIENT/PARENT/LEGAL REPRESENTITIVE: **DATE:**

If signed by other than parent state authority to do so

Witness: _____

Main Street Family Practice
675 Main Street
Melrose, Ma 02176
781-662-4934

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient: Date of birth: _____

_____
Patient Name/Previous Names

Address: _____

Phone: _____

Send information to MSFP OR Release information from MSFP

_____
Name of party to receive or send protected health information

_____
Mailing address

_____
City State Zip Code

Doctor Phone: _____ Doctor Fax: _____

INFORMATION TO BE USED /DISCLOSED:

___ Medical History, Visits, Reports
___ Treatment or Tests, X-Rays, EKG's
___ Immunizations
___ Other (Specify) _____
__ Surgical Reports
__ Hospital Records
___ Consultations

For the following dates of service: _____

PURPOSE FOR NEED OF DISCLOSURE: (check all applicable categories)

___Transferring to new physician/practice ___Insurance eligibility/benefits
___ Further Medical Care (not transferring care) ___ Legal Investigation or action
___ To allow discussion of and disclosure of information with above named party

I understand the **Main Street Family Practice does not copy records that are not originals or records sent to our office by your previous physician(s) or other providers of care.** I also understand that if the person(s) and/or organizations listed above are not healthcare organizations, health plans, or health care clearing houses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no