Winchendon Health Center
Member of the Heywood Healthcare Family

Authorization for the Release of Medical Records

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PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

Please check one: **Release TO Winchendon Health Center** _____ **Release FROM Winchendon Health Center** _____

PURPOSE OF RELEASE:
Medical Treatment _____ Personal Use* _____ Transfer to New Physician _____ Other_____

INFORMATION TO BE RELEASED:
All Records_____ (last 2 years for transfers) Specific Dates of Treatment: From _____ To_____
Clinic/Office Notes_____ X-Rays_____ Lab/Pathology Results_____ Immunizations_____

PHYSICIAN OR PERSON RECEIVING RECORDS:	**PHYSICIAN RELEASING RECORDS:**
Name_____	Name _____
Address_____	Address _____
City, State, Zip _____	City, State, Zip _____
Phone# _____Fax# _____	Phone# _____ Fax# _____

This authorization is valid for 90 days after the date signed, unless cancelled in writing. Please indicate if beyond 90 days or state INDEFINITELY: _____.

ONLY INFORMATION RELATED TO YOUR CARE AT THE WINCHENDON HEALTH CENTER WILL BE RELEASED FROM YOUR RECORD. WINCHENDON HEALTH CENTER WILL NOT RELEASE INFORMATION RECEIVED FROM OTHER FACILITIES/SPECIALISTS.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

SIGNATURE OF PATIENT / PARENT / LEGAL GUARDIAN (to be signed in presence of WHC staff member):

I, _____ agree to the release of my medical record information. I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric, venereal disease, social services and/or other sensitive protected information, I agree to its release.

_____ _____ _____
Signature of Patient, Parent, Legal Guardian Date Relationship to Patient

In addition, if you wish to release HIV/AIDS testing information you must sign and date below.

_____ _____
Signature Date

*NOTE: There is no fee for transfer of records to another health care provider for continued health care purposes. For personal purposes there is a fee of $.81 per page up to 100 pages and $.41 per page thereafter. For all other purposes (excluding Social Security and Workman's Comp) there is a flat fee of $23.89 in addition to $.81 per page up to 100 pages and $.41 per page thereafter.

Office Use Only *(last revised 5/8/2018)*
Type of Identification Viewed: License_____ Passport_____ State/Military ID _____ Other_____
Authorization Received By _____ Date _____