NEWTON-WELLESLEY NEUROLOGY ASSOCIATES

Authorization For Use or Disclosure of Medical Record Information

2000 Washington St. Green #567
Newton Lower Falls, MA 02462
(p) 617.928.1500
(f) 617.630.0860

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State _____ Zip: _____ Work Phone: _____

Release Information

I hereby authorize Newton-Wellesly Neurology to: ◯ Release my medical record information to: or ◯ Obtain information from:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ◯ Personal ◯ Referral or 2nd Opinion ◯ Legal ◯ Insurance ◯ Other _____

◯ Transfer from Practice/Reason? _____

Information to be Released

◯ Please provide a 2 year abstract of my medical record

◯ Please provide my entire medical record.

◯ Other - please be specific, include dates and MD's under comments.

Comments

Copy Fee: Pursuant to Chapter 135 of the Acts of 2003,"An Act Establishing Reasonable Fees for Copying Medical Records", Mass. Gen. L. ch. 11, §70, we reserve the right to charge a reasonable fee for the cost of producing and mailing the copies.

Authorization to Release Protected Information

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Release Records? Check one — *Initial each line below to confirm your choices*

I ☐ **DO** ☐ **DO NOT** want ***Mental Health Treatment Information** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released _____

I ☐ **DO** ☐ **DO NOT** want information about _____ released _____

Other sensitive information?

STOP Please confirm that you have put a checkmark and initialed **all** the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, NWNA may be unable to fulfill this request.

Sign Here _____ Date Here _____

Patient's Signature *(Parent, Legal Guardian, or Legal Representative) **Date***

Rev. 4/10

*Relationship to patient - If you are the legally recognized representative of the patient you must provide supporting documentation.

This Authorization is valid for 90 days unless you specify other wise (enter expiration date)_____. You may revoke this Authorization at any time by providing a written statement, except to the extent that Newton-Wellesley Neurology Associates has already completed action on it.
The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. Newton-Wellesley Neurology Associates will not condition treatment on payment of the provision of this Authorization.
Any information not to be released is specified above.