Emerson Primary Care of Bedford
55 North Road, Suite 120, Bedford, MA 01730
Phone: 339-215-5100 Fax: 339-215-5180

Emerson Hospital
Premium Care. Personal Touch.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____ Telephone**:** _____

Address: _____

I hereby authorize Emerson Primary Care of Bedford to release or obtain medical information to/from the individual/organization named below.

Records *RELEASED* to:

Name: _____

Street Address: _____

City/State/ZIP: _____

Phone: _____

Fax: _____

Records *OBTAINED* From:

Name: _____

Street Address: _____

City/State/ZIP: _____

Phone: _____

Fax: _____

This request and authorization applies to:

_____ Health information relating to the following treatment, condition, or dates: _____

_____

_____ All healthcare information

_____ Other: _____

CROSS OUT ANY ITEM BELOW YOU DO NOT WANT DISCLOSED

_____ YES _____ NO I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone. **DEFINITION:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, Immunodeficiency Syndrome), and gonorrhea.

_____ YES _____ NO I authorize the release of any records regarding substance abuse (drugs or alcohol use), mental health treatment (psychiatrist, psychologist, social worked, sexual counselor, etc.), mammography records, genetic testing, and abortion or family planning services, to the person(s) listed above.

Date: _____ Signature of Patient or Representative: _____

Print Name & Relationship if other than Patient: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS (90) DAYS AFTER IT IS SIGNED