



M.R. # \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone #

I authorize and request the release of medical records for treatment at:

Merrimack Valley Hospital     Other \_\_\_\_\_

Treatment Dates: \_\_\_\_\_

Person receiving information: \_\_\_\_\_

Purpose:  Personal     Legal     Continuing Care     Insurance

The specific information to be disclosed is:

- |                                                |                                             |                                           |
|------------------------------------------------|---------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Discharge Summary     | <input type="checkbox"/> Operative Report   | <input type="checkbox"/> Pathology Report |
| <input type="checkbox"/> Face Sheet            | <input type="checkbox"/> History & Physical | <input type="checkbox"/> X- Ray Report    |
| <input type="checkbox"/> Lab Reports           | <input type="checkbox"/> Consultation       | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> ER Visit              | <input type="checkbox"/> EKG Report         | <input type="checkbox"/> Stress Test      |
| <input type="checkbox"/> Other (specify) _____ |                                             |                                           |

*I understand that the medical record may contain information that is protected by law. However, I voluntarily consent to the disclosure for the purpose stated above. By initialing the following areas, I understand that this information will be released to the person/hospital listed above.*

**Please initial the information to be released:**

✦ Alcohol Abuse _____	✦ Psychiatric Treatment _____
✦ Drug Abuse _____	✦ AIDS/HIV Testing and/or Treatment _____

- A photocopy of this authorization shall have the same effect as the original.
- This authorization expires ninety (90) days from today's date.
- I have carefully read and understand the above statements, and do herein expressly and voluntarily consent to disclosure of the above information about, or medical records of, my condition to those persons or agencies named above. The person/agency receiving this information has been informed that any redisclosure of this information is prohibited by law without my further consent. This consent can be revoked in writing by the patient at any time except to the extent that action has already been taken.

Signature of Patient \_\_\_\_\_

Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_

Date \_\_\_\_\_