CHP Adams Internists
19 Depot Street, Suite 1
Adams, MA 01220
Phone #: (413) 743-1080

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

CHP is required by law to obtain your written permission to release your medical/dental information.

Patient's Name:_____ Date of Birth:_____

Address:_____ Phone #:_____

City, State, ZIP:_____

I authorize Community Health Programs to release the indicated portions of my medical records:

❑All Records ❑Immunizations ❑Last Physical ❑Test Results ❑Other (Please Specify)

Reason for Release: _____

Please release this information to: Name:_____
Address:_____
City, State, Zip:_____

Patient's Signature:_____ Date:_____

Legal Representative:_____ (60 day expiration)
(If patient is unable to sign, signature of person authorized and relationship to patient)

Witness:_____ Date:_____

All of my records may be released except the following:

❑HIV testing ❑AIDS related information ❑Alcohol abuse and/or treatment
❑Drug abuse and/or treatment ❑Psychiatric Evaluation and/or treatment ❑Sexually transmitted diseases

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Permission is hereby granted to Community Health Programs, Inc. to release my medical records as indicated, including any of the above indicated confidential information.

Patient's Signature:_____ Date:_____

Legal Representative:_____ (60 day expiration)
(If patient is unable to sign, signature of person authorized and relationship to patient)

Witness:_____ Date:_____

<u>This authorization is subject to revocation at any time</u>