Harbourside Family Practice
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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name: _____ DOB: _____
Address: _____ Phone:_____
_____ SSN: _____

I hereby authorize *Harbourside Family Practice* or their authorized employees to disclose protected health information to the following: (where you want records SENT)

Doctor or Practice Name: _____

Address: _____

Phone: _____ Fax: _____

I AUTHORIZE THIS RELEASE FOR THE FOLLOWING REASON: (Check one)

- ☐ Transfer of Care (reason) _____
- ☐ Communication with other providers, specialists, or consultants ___(Not Transferring)_____
- ☐ Other (please specify) _____

I understand that my medical record contains information relating to my diagnosis and treatment, and authorize the release of all such information including information relating to drug and/or alcohol abuse, psychiatric treatment, sexually transmitted disease or other sensitive information except for those items I have specified.

I authorize release of:

- ☐ Drug and/or Alcohol treatment records
- ☐ Psychiatric treatment records
- ☐ STD testing records (including HIV status)

Information I wish NOT to be disclosed (if applicable): _____

_____ _____
Signature of Patient or legal guardian Date

_____
Relationship to Patient

For large charts that cannot be faxed, there is a minimum charge of $10 for record transfers to cover copying, postage and administrative costs.

This authorization expires One Year from date signed.