RELEASE OF HEALTHCARE INFORMATION

Patient Name:_____ D.O.B.: _____ MR#:_____

This will authorize (MEDICAL PROVIDERS NAME) _____ and its related entities to use and/or disclose my protected health information for the following purpose.

❑ Name of person or entity receiving information: _____

_____

Street Address City State Zip Code Phone Number

Purpose: ❑ Insurance ❑ Legal Matter ❑ Personal ❑ School

Information to Be Disclosed.

Note: Information to be disclosed may include, as applicable, information related to mental health, drug or alcohol treatment, genetic testing, HIV/AIDS, and psychotherapy notes.

I authorize disclosure of the following information:

❑ Complete Medical Record

OR

❑ Records from the following dates: _____ to _____ .

OR

❑ I only want the following parts of my medical record to be disclosed, I will list them here:

_____

_____

If the choice I made above contains certain information I do not want disclosed, I will list it below:

_____

_____

Method of Delivery: ❑ Mail to receiving entity above ❑ FAX # _____

THIS COMMUNICATION IS FROM A DEBT COLLECTOR. THIS IS AN ATTEMPT TO COLLECT A DEBT. ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

- You may revoke this Authorization at any time, in writing, except to the extent that we have already relied upon it in making a disclosure. Your written revocation will become effective when we receive it. If you are providing this Authorization to obtain insurance coverage, you may not have the right to revoke the Authorization in the future to the extent that it pertains to the insurer's right under law to contest a claim under your insurance policy. If you wish to revoke this Authorization, please send your written request to: Gragil Associates, Inc., P.O. Box 1010, Pembroke, MA 02359.

- I understand that if I authorize disclosure of protected health information, the recipient may further disclose this information, and Federal law may no longer protect it.

_____

Signature of Patient or Legal Representative / Guardian Date

(Legal Handwritten Signature Accepted Only)

Form can be emailed, mailed or FAXED to:

Gragil Associates, Inc.
P.O. Box 1010
Pembroke, MA 02359
FAX: 781-826-6367
clientservices@gragil.com

THIS COMMUNICATION IS FROM A DEBT COLLECTOR. THIS IS AN ATTEMPT TO COLLECT A DEBT. ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.